FISCAL YEAR 2024

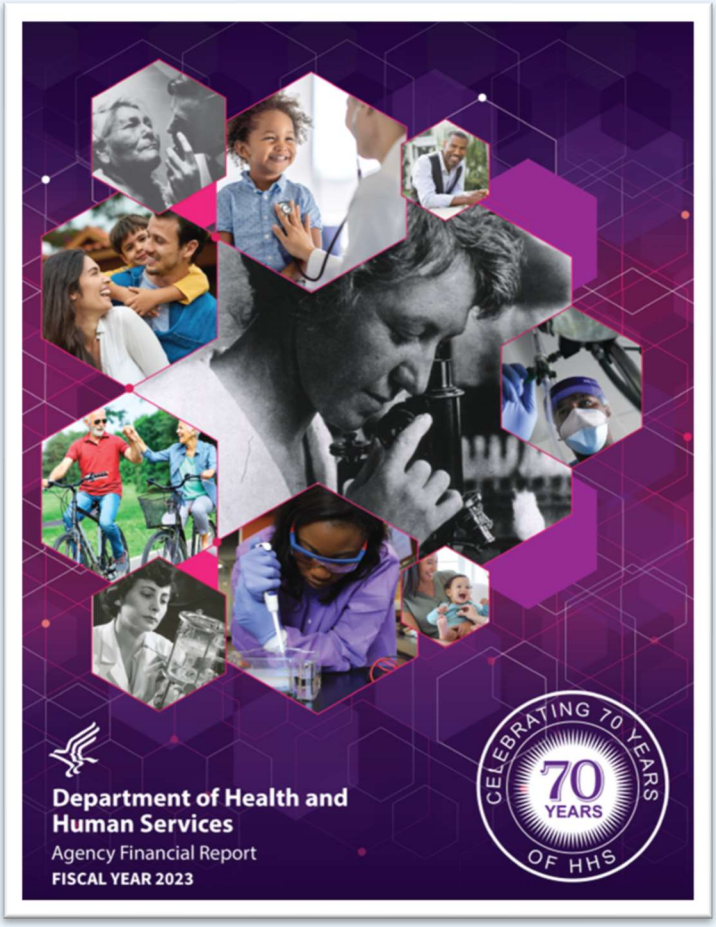
Agency Financial Report

Department of Health and Human Services

Certificate of Excellence in Accountability Reporting

The Department of Health and Human Services (HHS) promotes effective and responsible financial management by producing award-winning financial reports, aligning with its strategic plan. The AGA (formerly known as Association of Government Accountants) has recognized HHS's Agency Financial Report (AFR) for 11 consecutive years through the Certificate of Excellence in Accountability Reporting (CEAR) Program. The CEAR Program was established in collaboration with the Chief Financial Officers (CFO) Council and Office of Management and Budget to assist federal government agencies with performance and accountability reporting. Through this program, agencies improve accountability by streamlining reporting and enhancing the effectiveness of reports to clearly highlight agency accomplishments during a fiscal year (FY) and to discuss any challenges that remain.

The FY 2023 AFR exemplifies our dedication, spirit, and commitment to the HHS mission. Through another year of pandemic-related challenges, HHS's perseverance and efforts in FY 2023 continue to demonstrate award-winning results.



HHS's FY 2023 AFR was honored with a Best-in-Class Award for a new category "Informative Introductions for the Agency's Mission, Organization, and Report."

HHS is pleased to be the first agency receiving recognition in this category. AGA highlighted appealing use of visuals and text within the About the Agency Financial Report page, HHS Historical Timeline, and overview of the agency's functions and missions/responsibilities.

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Message from the Secretary

I am pleased to provide the Fiscal Year (FY) 2024 Agency Financial Report for the U.S. Department of Health and Human Services (HHS), which details how HHS invested resources this past fiscal year to accomplish its vital mission of advancing the health and well-being of the American people. We offer insight throughout this report on HHS's many accomplishments supporting the Department's five strategic goals, with just a few highlighted below.

Delivering on Our Strategic Goals

HHS protected and strengthened equitable access to high quality, affordable health care. During 2024's Marketplace Open Enrollment Period, 21.3 million people purchased insurance, including five million new enrollees. Following the *Inflation Reduction Act of 2022*, we required drug companies to pay rebates for drug prices that rose faster than inflation, capped out-of-pocket costs for many Medicare Part D enrollees, and saved taxpayers an estimated $6 billion by negotiating for fair prices on 10 critical medications for Medicare enrollees. We invested in growing the health care workforce, including 42 programs aimed at improving care for seniors, and finalized national minimum staffing requirements for nursing homes. These are among the many initiatives to reduce health care costs and expand access to care for many Americans.

We safeguarded and improved national and global health conditions and outcomes. One area of particular concern is strengthening maternal care and infant health; this year we invested over $135 million in the Healthy Start program, the Community-Based Maternal Behavioral Health Services Program, and the Rural Maternity and Obstetrics Management Strategies and Delta Region Maternal Care Coordination programs. We also protected reproductive health care by preserving access to assisted reproductive technology like in-vitro fertilization with a new rule under the *Health Insurance Portability and Accountability Act of 1996* and educating pregnant women about their rights to emergency medical care and hospitals about their obligations under the *Emergency Medical Treatment and Labor Act*. HHS will continue tackling health disparities on many fronts.

We strengthened social well-being, equity, and economic resilience by investing in programs that improve behavioral health, modernize opioid treatment programs, and lower the rate of overdoses. We awarded over $1 billion through the Community Mental Health Services Block Grant program, which serves approximately 8.3 million people by treating early serious mental illness, strengthening crisis response systems, improving behavioral health for racial and ethnic minorities and underserved populations, and supporting a variety of behavioral health and overdose prevention initiatives. Because of these investments, drug overdose deaths fell three percent in 2024 – the first decline in more than five years. HHS is proud of how these programs strengthened behavioral health in our country and we will continue striving toward new milestones.

We restored trust and accelerated advancements in science and research for all by investing in cutting edge work, including over $1.9 billion total – $500 million this year alone – for Project NextGen to accelerate innovative next-generation vaccine and therapeutics platforms to ensure effective treatments are accessible during future pandemics. And we are restoring trust in our research by establishing methodologies to identify and resolve bias in artificial intelligence (AI) models used in research applications for biomedicine, behavioral, and social sciences, and health.

We advanced strategic management to build trust, transparency, and accountability. HHS recently restructured to streamline and bolster technology, cybersecurity, data, and AI strategy and policy functions. We are also implementing the 2023 HHS Data Strategy and doing our part for the National Cybersecurity Strategy by taking steps to ensure hospitals and communities vulnerable to cyberattacks are better prepared and more secure. HHS takes its public trust seriously and continues to improve our critical health systems and better safeguard data.

Stewardship

HHS maintains a comprehensive, sound system of management controls to ensure this report is complete and reliable. For the 26th consecutive year, we obtained an unmodified (clean) opinion on our FY 2024 Consolidated Balance Sheets, Statements of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts due to the uncertainties surrounding provisions of the *Patient Protection and Affordable Care Act* and the impact of potential legal changes affecting underlying assumptions of financial projections. These statements were developed based on current law using information in the 2024 Medicare Trustees Report. The "Financial Section" includes more detailed information.

HHS conducted its assessment of the effectiveness of internal controls over reporting in accordance with the Office of Management and Budget's Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control.* Based on assessments, other than an identified material noncompliance with the *Payment Integrity Information Act of 2019,* I can provide reasonable assurance the financial and performance information contained in this report is complete, reliable, and accurate. The "Management's Discussion and Analysis" section includes details.

Strong Foundation for Future Success

HHS strives every day to advance the health and well-being of the American people, investing in health infrastructure with a whole-person and whole-family view of health and wellness while staying true to our guiding principles. As stewards of taxpayer funds, we will continue pursuing smart innovation and improved processes while providing the highest level of service, and we will protect our stakeholders and prepare for future uncertainties by strengthening public health systems in every community. HHS will continue building on this foundation of demonstrated success and delivering on our promises for years to come.

/Xavier Becerra/

Xavier Becerra
Secretary
November 14, 2024

About the Agency Financial Report

The HHS FY 2024 AFR provides fiscal and summary performance results that enable the President, Congress, and the American people to assess our accomplishments for the reporting period October 1, 2023, through September 30, 2024. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We prepared this report in accordance with the requirements of Office of Management and Budget Circular A-136, *Financial Reporting Requirements.* The AFR consists of three primary sections and a supplemental section for the appendices.

Section 1 – The Management's Discussion and Analysis section provides an overview of HHS's mission, activities, organizational structure, program performance, and forward looking information. Section 1 also includes an overview of the systems environment; a summary of HHS's financial results and compliance with laws and regulations; and management's assurances on HHS's internal controls.

Section 2 – The Financial section begins with a message from the Office of the Assistant Secretary for Financial Resources. Section 2 continues with the independent auditor's report, management's response to the audit report, financial statements with accompanying notes, and required supplementary information, including the Combining Statement of Budgetary Resources, Deferred Maintenance and Repairs, and Social Insurance information.

Section 3 – The Other Information section contains additional information, such as other financial information, the summary of the financial statement audit and management assurances, civil monetary penalties, grant closeout reporting, and a detailed payment integrity report. Section 3 concludes with the Office of Inspector General's assessment of the Top Management and Performance Challenges Facing HHS.

Section 4 – The Appendices section includes information that supports the sections of the AFR, such as the glossary of acronyms used in the report and additional resources for connecting with HHS.

Additional reports will be released on the HHS website in February 2025 including:

- FY 2026 *Annual Performance Plan and Report*

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SECTION 1:

MANAGEMENT'S DISCUSSION AND ANALYSIS

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Looking Ahead to 2025
- Analysis of Systems, Legal Compliance, and Internal Control
- Management Assurances
- Financial Summary and Highlights

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About the Department of Health and Human Services

The mission of the United States (U.S.) Department of Health and Human Services (HHS or the Department) is to enhance the health and well-being of all 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 is the 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. HHS accomplishes its mission through a variety of programs, initiatives, and activities working together to promote and protect the health of the American people. HHS is responsible for approximately a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) together provide care for more than 160 million Americans.

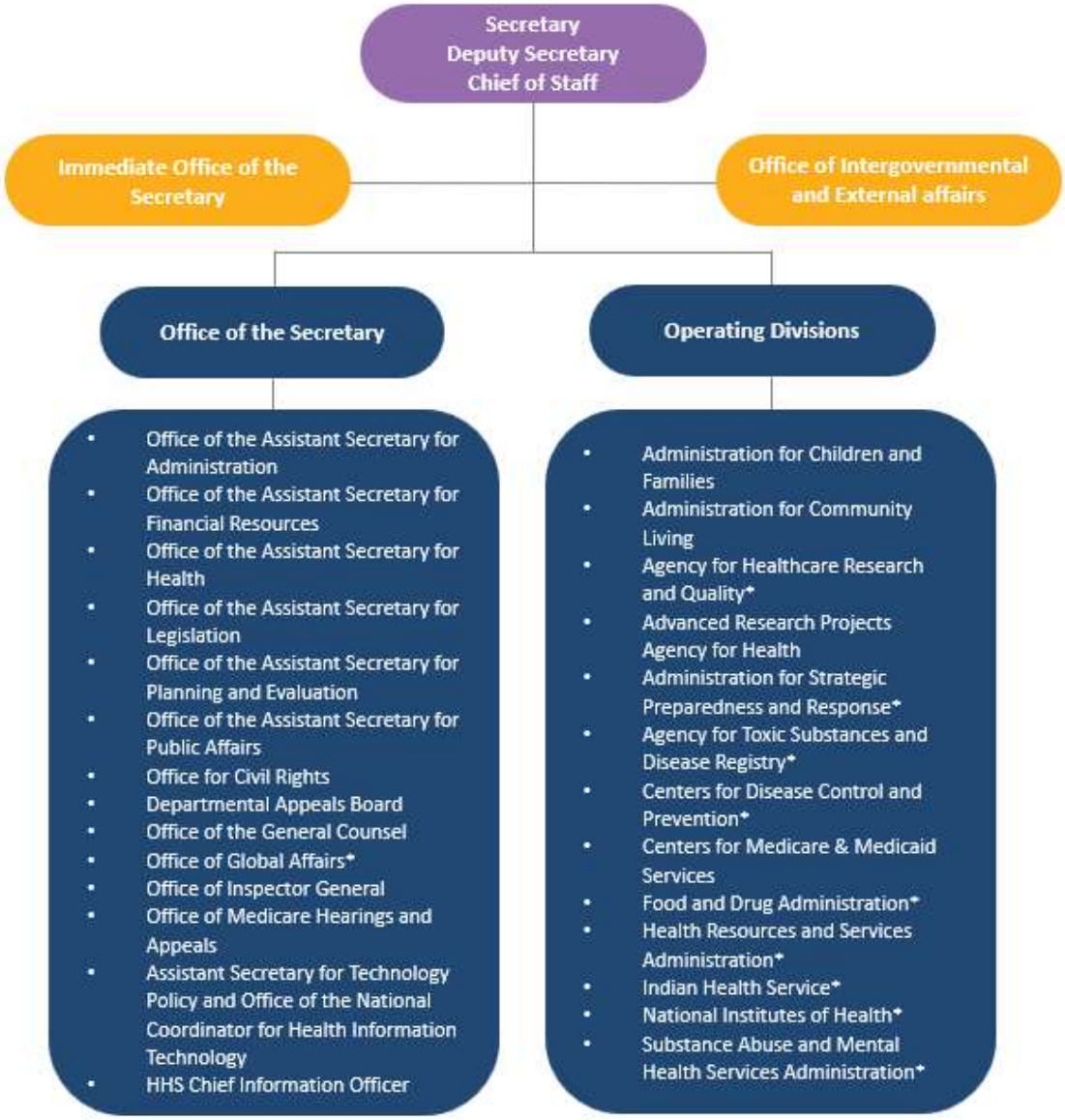
HHS works closely with U.S. state, local, territorial, and tribal governments and agencies, and private sector recipients that provide many HHS-funded services at the local level. While HHS is a domestic agency, the interdependence of our world requires that HHS engage globally to fulfill its mission. The HHS Office of the Secretary (OS) and the 13 Operating Divisions (OpDivs) administer a wide variety of HHS's programs and conduct life-saving research for the nation, protecting and serving all Americans. In addition, Staff Divisions (StaffDivs) within OS provide leadership, direction, and policy and management guidance to the Department. Nine OpDivs and one StaffDiv are components of the U.S. Public Health Service.

Through its programs and partnerships, HHS:

- Promotes health and disease prevention by offering resources that help the American people eat smart, exercise regularly, and get routine health screenings and vaccinations;
- Leads the nation's medical and public health communities in preparing for, responding to, and recovering from disasters and public health emergencies;
- Strengthens early childhood development and expands opportunities to help children and youth thrive equitably within their families and communities;
- Provides education and training opportunities for health professionals and students, including loans, scholarships, and training programs;
- Helps families and individuals stay safe and informed about food, drugs, medical devices, violence prevention, and more;
- Protects patients' rights of nondiscrimination and privacy in healthcare delivery through enforcement of federal rights, and through education and guidance of healthcare providers and covered entities; and
- Invests in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services, resulting in more effective interventions, treatments, and programs.

Organizational Structure

HHS's organizational structure is designed to accomplish its mission and provide a framework supporting sound business operations and management controls. Led by the HHS Secretary, OS establishes the overarching vision and strategic direction for the Department and its OpDivs to provide a wide range of services and benefits for the American people. For more information, refer to HHS's website.



*Components of the U.S. Public Health Service

Each OpDiv contributes to the HHS mission as follows:

Administration for Children and Families (ACF)

ACF's mission is to foster health and well-being by providing federal leadership, partnership, and resources for the compassionate and effective delivery of human services. Through ACF's Strategic Plan, programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, and supportive communities that have a positive impact on the quality of life and development of children. ACF seeks to establish partnerships with front-line service providers, states, localities, and tribal communities to identify and implement solutions that transcend traditional program boundaries. ACF also works to improve access to services through planning, reform, and integration, as well as address the needs, strengths, and abilities of vulnerable populations, including refugees and migrants.

Administration for Community Living (ACL)

ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across their lifespan, and their families and caregivers. ACL was created around the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and with the ability to participate fully in their communities. ACL helps make this principle a reality for millions of Americans by funding services and support efforts provided primarily by networks of community-based organizations, and with investments in research, education, and innovation. ACL's Strategic Framework captures the opportunities and challenges created by the aging of the U.S. population and defines goals and objectives for addressing critical aging issues.

Did You Know?

ACF celebrates 60 years of community action through the Community Services Block Grant (CSBG). CSBG provides funds to states, territories, and tribes to administer to support services that alleviate the causes and conditions of poverty in under resourced communities. Over 9 million individuals are served by CSBG-funded programs annually.

Agency for Healthcare Research and Quality (AHRQ)

AHRQ's mission is to improve healthcare for all by producing evidence to make healthcare of higher quality so that it is safer, patient centered, timely, effective, accessible, efficiently provided and equitably distributed. AHRQ accomplishes its mission working within HHS and with the states, territories, tribal nations, and private partners to make sure that the evidence is understood and used.

Administration for Strategic Preparedness and Response (ASPR)

ASPR's mission is to assist the country in preparing for, responding to, and recovering from public health emergencies and disasters. ASPR accomplishes its mission by developing, stockpiling, and distributing response tools against multiple threats; sending clinical response teams to places in times of crisis; and ensuring our healthcare and public health partners have the knowledge and tools they need to navigate today's challenges and confront whatever challenges lay ahead. ASPR aims to strengthen their mission by focusing on four strategic goals within their Strategic Plan: (1) Preparedness, (2) Manage the Federal Response, (3) Improve and Leverage Partnerships, and (4) Ensure Workforce Readiness.

Advanced Research Projects Agency for Health (ARPA-H)

ARPA-H's mission is to accelerate better health outcomes for everyone by supporting the development of high-impact solutions to society's most challenging health problems. To accomplish its mission, ARPA-H has implemented its Strategic Plan to address the most urgent challenges in the health ecosystem. Through exclusive engagement and intentional design of programs that ensure ARPA-H's key tenants of accessibility and customer experience, ARPA-H aims to ensure access to solutions regardless of demographics or geography. ARPA-H leverages diverse perspectives for sustained equity across policy, practices, and programs. In FY 2024, ARPA-H reported under the National Institutes of Health.

Agency for Toxic Substances and Disease Registry (ATSDR)

ATSDR's mission is to protect communities from harmful health effects related to exposure to natural and man-made hazardous substances. ATSDR does this by responding to environmental health emergencies; investigating emerging environmental health threats; conducting research on the health impacts of hazardous waste sites; and building capabilities of and providing actionable guidance to state and local health partners. ATSDR reports under the Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention (CDC)

CDC's mission is to work around the clock to protect America from health, safety, and security threats, both foreign and domestic. To accomplish its mission, CDC conducts critical science, provides health information that protects our nation against expensive and dangerous health threats, and responds when these threats arise. CDC's Strategic Plan leverages five core capabilities: (1) Diverse Public Health Workforce; (2) World-class Data and Analytics; (3) State-of-the-Art Laboratories; (4) Rapid Response to Outbreaks at Their Source; and (5) Strong Global Capacity and Domestic Preparedness, which all reflect the commitment to equity and diversity and lifting up where CDC invested through the COVID-19 pandemic.

Centers for Medicare & Medicaid Services (CMS)

CMS's mission is to lead the advancement and integration of health equity in the development, evaluation, and implementation of CMS's policies, programs, and partnerships. To accomplish its mission, CMS provides health coverage to more than 160 million people through Medicare, Medicaid, CHIP, and the Health Insurance Exchange. Over the last 50 years, CMS evolved into the largest purchaser of healthcare and now houses the nation's largest collection of healthcare data. CMS works in partnership with the entire healthcare community to improve quality, equity, and outcomes in the healthcare system. CMS's strategic vision focuses on delivering meaningful, person-centered, and equitable care through six strategic pillars: (1) Advance Equity; (2) Expand Access; (3) Engage Partners; (4) Drive Innovation;(5) Protect Programs; and (6) Foster Excellence.

Food and Drug Administration (FDA)

FDA's mission is to protect the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation. FDA is responsible for advancing the public health by helping speed innovations that make medical products safer, more effective, and more affordable, thus helping the public get the accurate, science-based information they need to use medical products and foods to maintain and improve their health. FDA regulates the manufacturing, marketing, and distribution of tobacco products to protect the public health and reduce tobacco use by minors. Finally, FDA plays a significant role in the nation's counterterrorism capability by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats.

Health Resources and Services Administration (HRSA)

HRSA's mission is to improve health outcomes and achieve health equity through access to quality services, a skilled health workforce, and innovative, high-value programs. HRSA provides equitable healthcare to the nation's highest-need communities–serving people who are geographically isolated and economically or medically vulnerable. HRSA programs support people with low incomes, people with human immunodeficiency virus (HIV), pregnant people, children, parents, rural communities, transplant patients, and other communities in need, as well as the health workforce, health systems, and facilities that care for them. HRSA's Strategic Plan outlines a vision for healthy communities and people through four goals: (1) Take Actionable Steps, (2) Improve Access, (3) Foster a Health Workforce and Health Infrastructure to Address Needs, and (4) Optimize Operations and Strengthen Program Engagement.

Indian Health Service (IHS)

IHS's mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. Three strategic goals expand upon IHS's mission: (1) Ensure Comprehensive, Appropriate Personal and Public Health Services Availability, (2) Promote Excellence and Quality Through Innovation, and (3) Strengthen IHS Program Management and Operations. IHS creates healthy communities and quality healthcare systems through strong partnerships and culturally responsive practices. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. IHS provides a comprehensive health service delivery system for approximately 2.8 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states.

National Institutes of Health (NIH)

NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. NIH applies its leadership and knowledge to provide direction to programs designed to improve the health of the nation. NIH seeks to foster fundamental creative discoveries, innovative research strategies, and establish their applications as a basis for ultimately protecting and improving health. The NIH-Wide Strategic Plan outlines its vision for biomedical research direction, capacity, and stewardship.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. SAMHSA leads public health efforts to advance the behavioral health of the nation and improve the lives of individuals living with mental and substance use disorders (SUD), and their families. SAMHSA envisions that people with, affected by, or at risk for mental health and substance use conditions receive care, achieve well-being, and thrive. SAMHSA's efforts prioritize equity, trauma-informed approaches, recovery, and a commitment to data and evidence. SAMHSA's Strategic Plan focuses on five key priority areas: (1) Preventing Substance Use Overdose; (2) Enhancing Access to Suicide Prevention and Mental Health Services; (3) Promoting Resilience and Emotional Health for Children, Youth, and Families; (4) Integrating Behavioral and Physical Healthcare; and (5) Strengthening the Behavioral Health Workforce.

Did You Know?

IHS has reported notable achievements in their Director's Year Two Accomplishment Report, showing progress in four key areas, reflecting IHS's ongoing mission to improve the health and well-being of American Indians and Alaska Natives:

- Implementing historical legislation and investments, including implementing the Bipartisan Infrastructure Law (BIL), which provides $3.5 billion to the IHS to develop critical healthcare infrastructure.
- Lowering costs for Americans and growing the economy, through steps like the construction of new facilities across Indian Country like the Gallup Indian Medical Center 14-bed emergency department and the $100 million, 100,000-square-foot expansion of behavioral health care facilities at Alaska's Southcentral Foundation.
- Defending freedoms and protecting civil rights and liberties through implementation of its first-ever advance appropriations for FY 2024, accomplishing fiscal year transition activities swiftly, allowing them to initiate the disbursement of FY 2024 funds within days of the fiscal year's start. In addition, IHS recognized the Santa Fe Indian Health Center and the Crownpoint Health Care Facility as the first federal facilities to earn National Voter Registration Act (NVRA) designation.
- Ensuring America remains strong, secure, and a global leader through its Electronic Health Record (EHR) Modernization, which saw advancement in the adoption of a new EHR. From engaging in extensive consultation to the recruitment of experts and implementation staff, the fiscal year ended with IHS announcing its first pilot site in September 2024.

About the Department of Health and Human Services

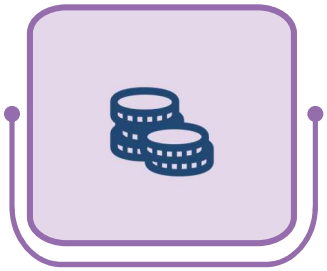
The following StaffDivs report directly to the HHS Secretary as they manage Department programs and support the OpDivs in carrying out the Department's mission:

Immediate Office of the Secretary (IOS)

IOS is responsible for Department operations and coordinates the work of the Secretary through two offices: the Executive Secretariat and the Office of Intergovernmental and External Affairs. The Executive Secretariat manages the Department's policy review and decision-making processes, and coordinates the development, clearance, and submission of all policy documents for the Deputy Secretary and Secretary's review and approval. The Office of Intergovernmental and External Affairs represents both the government and external perspective in federal policymaking and clarifies the federal perspective to government officials and external parties.

Assistant Secretary for Administration (ASA)

ASA provides leadership for HHS departmental administration by overseeing the areas of human resource policy, equal employment opportunity, diversity, facilities management, information technology, and the Department's service operations. The Program Support Center, a component of ASA, is a shared services organization dedicated to providing support services to help its customers achieve mission-critical results.



Office of the Assistant Secretary for Financial Resources (ASFR)

ASFR provides advice and guidance to the HHS Secretary on all aspects of budget, financial management, grants management, and acquisition management, and provides direction for implementing these activities across the Department.

Office of the Assistant Secretary for Health (OASH)

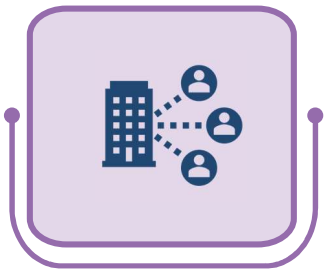
OASH oversees the Department's key public health offices and programs, a number of Presidential and Secretarial advisory committees, 10 regional health offices across the nation, Office of the Surgeon General, and the U.S. Public Health Service Commissioned Corps. Under OASH, the Office of Climate Change and Health Equity (OCCHE) was established with the mission to protect the health of people throughout the U.S. in the face of climate change, especially those experiencing a higher share of exposures and impacts. OCCHE provides expertise and coordination related to climate change and health equity to HHS, other federal agencies, and the White House. In June 2024, HHS took a significant step towards addressing the challenges posed by climate change, by releasing an updated 2024 – 2027 Climate Adaptation Plan.

Office of the Assistant Secretary for Legislation (ASL)

ASL serves as the primary link between the Department and Congress for the HHS Secretary and is responsible for developing and implementing HHS's legislative agenda.

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

ASPE advises the Secretary on policy development in health, disability, human services, data, and science, and provides advice and analysis on economic policy. ASPE leads special initiatives; coordinates the Department's evaluation, research, and demonstration activities; and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies; develops policy analyses; and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

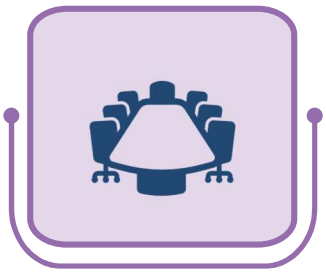


Office of the Assistant Secretary for Public Affairs (ASPA)

ASPA serves as the Secretary's principal counsel on public affairs and provides centralized leadership and guidance for HHS's StaffDivs, OpDivs, and regional health offices. ASPA manages the Department's digital communications and administers the Freedom of Information and Privacy Acts. The Division leads the efforts for planning, developing, and implementing emergency incident communications strategies and activities for the Department.

Office for Civil Rights (OCR)

As HHS's civil rights law enforcement agency, OCR enforces 55 civil rights, conscience and religious freedom, cybersecurity and privacy laws by investigating complaints; developing policy; promulgating regulations; and working with the public to drive compliance with the law to protect privacy, security, and civil rights. OCR also educates the public about federal civil rights and conscience laws that prohibit recipients of HHS federal financial assistance from discriminating on the basis of race, color, national origin, religion, disability, age, sex, and conscience. OCR works to promote and protect health information privacy and national security of the nation's healthcare systems, including implementing and enforcing the *Health Insurance Portability and Accountability Act* (HIPAA) Privacy, Security, and Breach Notification Rules, and the *Patient Safety Act and Rules*.

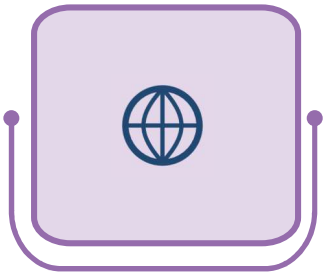


Departmental Appeals Board (DAB)

DAB provides impartial and independent review of disputed legal decisions in a wide range of Department programs for more than 60 statutory provisions. DAB resolves disputes with outside parties such as state agencies, Head Start recipients, universities, nursing homes, doctors, and Medicare beneficiaries. DAB conducts *de novo* reviews of administrative law judge action from the Office of Medicare Hearings and Appeals.

Office of the General Counsel (OGC)

OGC provides quality representation and legal advice to the Department on a wide range of highly visible national issues. OGC supports developing and implementing the Department's programs through sound legal services to the HHS Secretary and the organization's various agencies and divisions.



Office of Global Affairs (OGA)

OGA acts as the diplomatic voice of the Department by providing leadership and expertise in global health diplomacy and policy. Through relationships with multilateral organizations, foreign governments, ministries of health, civil society groups, and the private sector, OGA creates and maintains the pathways for HHS to apply its expertise globally, learn from its overseas counterparts, and advance policies that protect and promote health at home and worldwide.

Office of Inspector General (OIG)

OIG provides objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of program participants. OIG aims to drive positive change in HHS programs and in the lives of the people served by these programs.

Did You Know?

Thirty-five years ago, in 1989, Congress took a significant step when it elevated the National Center for Health Services Research and Health Care Technology Assessment to full agency status, creating what was then known as the Agency for Healthcare Policy and Research. This pivotal moment recognized health services research (HSR) as a fundamental component of healthcare and a key to improving healthcare delivery. In 1999, Congress renamed the Agency as AHRQ, reaffirming and codifying our role not just as a funder of scientific research, but as the federal home of HSR.

About the Department of Health and Human Services

Office of Medicare Hearings and Appeals (OMHA)

OMHA administers nationwide hearings for the Medicare program for appeals arising from individual claims for Medicare coverage and payment for items and services furnished to beneficiaries under Medicare Parts A, B, C, and D. OMHA also hears appeals arising from Medicare benefits entitlement claims and Medicare Medical Insurance (Part B) and Medicare Prescription Drug Benefit (Part D) premium appeals disputes. OMHA operates separately from the other agencies involved in the Medicare claims appeal process.

Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC)

ASTP/ONC is at the forefront of the Administration's health information technology (IT) efforts and serves as a resource to the entire health system, supporting the adoption of health IT and promoting nationwide standards-based health information exchange to improve healthcare. ATSP focuses on two objectives: (1) Advancing the Development and Use of Health IT Capabilities and (2) Establishing Standards for Data Sharing.

HHS Chief Information Officer (CIO)

The Office of the CIO establishes and provides assistance and guidance on the use of technology-supported business process reengineering; investment analysis; performance measurement; strategic development and application of information systems and infrastructure; policies to provide improved management of information resources and technology; and better, more efficient service to our clients and employees.

For more information regarding our organization, visit HHS's website.

Performance Goals, Objectives, and Results

Overview of Strategic and Agency Priority Goals

The *Government Performance and Results Act of 1993* (GPRA) and the *GPRA Modernization Act of 2010* require federal agencies to update their Strategic Plan every 4 years at the beginning of an Administration's new term. The strategic plan presents HHS's vision, identifies the agency's goals and objectives, and describes HHS's planned actions to manage challenges and achieve those goals.

The HHS Strategic Plan defines its mission, goals, and strategies and how the Department will measure its progress to address complex, multifaceted, and evolving healthcare, public health, and human services issues. The Department's OpDivs and StaffDivs contribute to the development and successful execution of the HHS Strategic Plan.

Performance Management

Performance goals and measures are powerful tools to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions, gauge meaningful progress toward objectives, and identify cost-efficient ways to achieve results. HHS continues to implement significant performance management improvements that include:

- Developing, analyzing, reporting, and managing Agency Priority Goals (APGs), and conducting performance reviews among OpDivs, StaffDivs, and HHS leadership to monitor progress toward achieving key performance objectives;
- Identifying performance measures to support the achievement of the HHS Strategic Plan and achievement of OpDiv and StaffDiv budget requests; setting ambitious yet realistic targets, aiming to achieve 70 to 75 percent of all targets set;
- Conducting strategic reviews to support decision-making and performance improvement across HHS;
- Coordinating performance measurement, budgeting, strategic planning, enterprise risk management (ERM), and evidence-building activities within the Department;
- Holding quarterly data-driven meetings with senior leaders of major OpDivs (ACF, CDC, CMS, FDA, HRSA, IHS, NIH, and SAMHSA) on organizational health and performance;
- Fostering a network of OpDiv and StaffDiv Performance Officers who support, coordinate, and implement performance management efforts across HHS; and
- Sharing performance management best practices at HHS through webinars and other media.

Data Quality

HHS follows *GPRA Modernization Act of 2010* guidelines for reporting data quality and works to improve the performance data quality as one type of evidence used in policymaking over time consistent with the *Foundations for Evidence-based Policymaking Act of 2018* (also referred to as the *Evidence Act*). For information on HHS's *Evidence Act* activities, visit Evaluation.gov. OpDivs and StaffDivs certify their data quality on an annual basis for all measures that appear in the HHS Strategic Plan, including:

- Processes used to verify and validate measured values;
- Data sources;
- Confirmation that the data meets the level of accuracy required for its intended use;
- Limitations to the data at the required level of accuracy; and
- Compensation for such limitations, if needed, to reach the required level of accuracy.

Each OpDiv and StaffDiv certifies that its data undergoes a thorough quality assurance process and provides a signed letter of attestation to the HHS Performance Improvement Officer. Data quality information for APG measures are included in each APG Action Plan, located on Performance.gov.

HHS Strategic Plan

The HHS Strategic Plan FY 2022 – 2026 has five strategic goals, representing input from HHS OpDivs and StaffDivs, along with public comments. HHS aligns its focus, strategies, and activities to achieve these strategic goals and objectives. The five strategic goals are:

HHS FY 2022 – 2026 Strategic Goals and Objectives

Strategic Goal 1:

Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare

1.1 Increase choice, affordability, and enrollment in high quality healthcare coverage

1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs

1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally competent healthcare services while addressing social determinants of health

1.4 Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families

1.5 Bolster the health workforce to ensure delivery of quality services and care

Strategic Goal 2:

Safeguard and Improve National and Global Health Conditions and Outcomes

2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from disasters, public health and medical emergencies, and threats across the nation and globe

2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines

2.3 Enhance promotion of healthy behaviors to reduce occurrence of and disparities in preventable injury, illness, and death

2.4 Mitigate the impacts of environmental factors, including climate change, on health outcomes

Strategic Goal 3:

Strengthen Social Well-Being, Equity, and Economic Resilience

3.1 Provide effective and innovative pathways leading to equitable economic success for all individuals and families

3.2 Strengthen early childhood development and expand opportunities to help children and youth thrive equitably within their families and communities

3.3 Expand access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life

3.4 Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence

Strategic Goal 4:

Strategic Goal 4:

Restore Trust and Accelerate Advancements in Science and Research for All

4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion

4.2 Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs

4.3 Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions

4.4 Improve data collection, use, and evaluation to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience

Strategic Goal 5:

Strategic Goal 5:

Advance Strategic Management to Build Trust, Transparency, and Accountability

5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices

5.2 Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust

5.3 Uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission

5.4 Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices

Agency Priority Goals

APGs are a set of ambitious but realistic performance objectives the Department expects to achieve within a 24-month period. These HHS-wide goals provide cohesive themes for the Secretary's priorities and support objectives of the HHS Strategic Plan. APGs include performance measure reporting to track HHS progress and provide a strong representation of how the Department meets the HHS mission. APG results rely on strong agency implementation and do not require new legislation or additional funding. General areas of focus for APGs include customer service, efficiencies, and advances toward longer-term, outcome-focused strategic goals and objectives.

The FY 2024 – 2025 APGs are:

Advancing Customer Experience (Strategic Objective 5.1)

APG Goal Statement

HHS builds trust and improves customer experience by simplifying its procedures, saving people time, and delivering results while maintaining program integrity. By September 30, 2025, HHS will enhance foundational Customer Experience (CX) capacity by reporting on trust and other service-level experience measures for HHS OpDivs.

Discussion of Progress

In FY 2024, HHS made significant progress on its CX APG through improving core services for customers and building the Department's CX capacity. To improve service delivery for customers, the Department launched 14 flagship CX projects across every OpDiv aimed at reducing administrative burdens and improving the accessibility and ease of use of services for customers. Each OpDiv conducted assessments of their CX capabilities, identified key customers, and developed plans for improving a core service. All 14 projects are now underway, and teams are making progress while providing quarterly updates to senior leadership as part of the Department's APG progress reporting. Additionally, all 14 project teams are taking part in a 6-month CX training program that includes biweekly workshops on CX topics and individualized coaching.

To build CX capacity within HHS, the Department launched the HHS CX Community of Practice to share resources, create connections among staff working on or interested in CX, and develop important CX skills. The community meets monthly for expert presentations, trainings, and collaboration opportunities. During CX assessments and project planning with OpDivs, the Department identified common administrative barriers; as a result, HHS is streamlining policies regarding customer research incentives. The Department has partnered with the Office of Management and Budget (OMB) to obtain Paperwork Reduction Act Generic Clearances for CX-related activities at HHS, creating fast-track approval processes for staff working on CX. HHS has also streamlined efforts to gather feedback from program participants and facilitated cross agency sharing of knowledge and expertise.

This APG contributes to the HHS Strategic Plan FY 2022-2026 Objective 5.1: Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.

Behavioral Health (Strategic Objective 1.4)

APG Goal Statement

HHS is committed to improving health outcomes for those affected by behavioral health conditions. HHS will continue to improve these outcomes by increasing access and utilization of prevention, crisis intervention, treatment, and recovery services. By September 30, 2025, HHS will reduce emergency department (ED) visits for acute alcohol use, mental health conditions, suicide attempts, and drug overdose by 10 percent compared to the FY 2023 baseline.

Discussion of Progress

Halfway through the APG performance period, the Behavioral Health APG has shown encouraging progress toward reaching its goals. The rates of ED visits for suicide attempts and drug overdoses are showing decreases compared to the FY 2023 baselines. The rate of ED visits for mental health conditions has remained relatively stable during the performance period. The rate of ED visits for alcohol use is trending upward. This trend may reflect wider trends in polysubstance use in the U.S., as alcohol is the most common drug used in combination with other substances.

Additionally, the APG team comprised of CDC, SAMHSA, and HRSA has made strides toward increasing access and utilization of prevention services. The Maternal Mental Health Hotline, run by HRSA, is seeing increased quarterly contact volume. The increase in calls can be attributed to press and promotions marking the Hotline's second anniversary in May 2024. SAMHSA and CDC engaged with over 50 federal staff from across the federal government on the National Strategy for Suicide Prevention. CDC and SAMHSA have also partnered with communications and behavioral science experts from multiple federal agencies on best practices for major communication campaigns for the Suicide Prevention Communications Playbook.

This APG contributes to the HHS Strategic Plan FY 2022-2026 Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and SUD treatment and recovery services for individuals and families.

HHS Performance Results

In FY 2024, HHS monitored over 900 performance measures to improve the efficiency and effectiveness of departmental programs and activities. This includes all performance measures published in Congressional Justifications. From the 900+ budget measures, HHS tracked performance on nearly 90 Strategic Plan measures, which are included in the Annual Performance Plan and Report.

HHS will report on FY 2024 Strategic Plan results in the FY 2024 Annual Performance Report, scheduled for publication in January 2025.

FY 2023 Strategic Plan Results

Overall, in FY 2023, HHS reports meeting or exceeding targets for 54 percent of the performance measures which support the Strategic Plan, with 19 percent of measures still pending. Many of HHS's grant programs face data lags in collecting, aggregating, and reporting on performance data, which contributes to the 19 percent of measures pending results for the FY 2023 period of performance.

Figure 1: FY 2023 Measures – Performance Status of Strategic Plan Measures

Performance Status	Number of Measures	Percent of All Strategic Plan Measures	Percent of All Strategic Plan Measures, Excluding Pending & Other Status
Target Exceeded	32	--	--
Target Met	16	--	--
Subtotal	**48**	**54%**	**72%**
Target Not Met but Improved	5	--	--
Target Not Met	14	--	--
Subtotal	**19**	**21%**	**28%**
Pending	17	--	--
Other Status (baseline, no target, historical actual, not collected, etc.)	5		
Subtotal	**22**	**25%**	**N/A**

Did You Know?

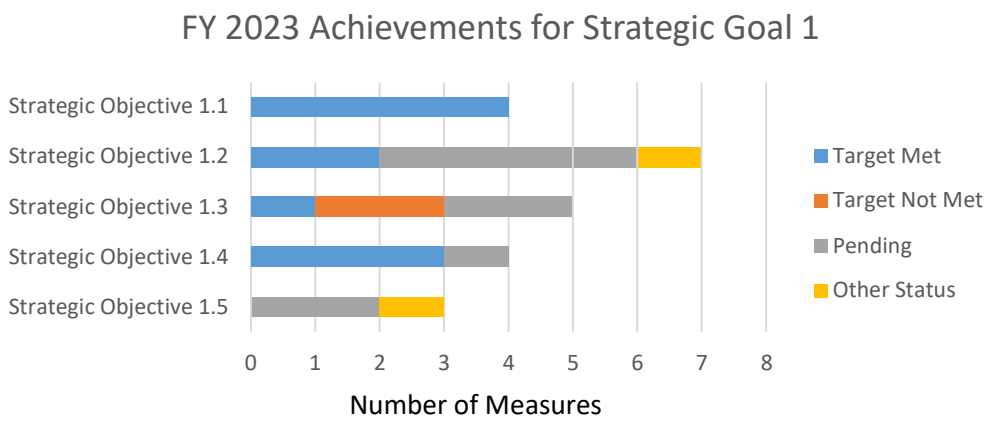
On Tuesday, January 31, the HHS hosted its first-ever Food is Medicine summit in Washington, D.C., an all-day summit for stakeholders at the intersection between food and health. Secretary Xavier Becerra opened the summit by announcing three new public-private partnerships with Instacart, Rockefeller Foundation, and Feeding America. All three partnerships will support HHS's nutrition goals.

Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare

Supporting Divisions – ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, NIH, ASPE, OASH, OCR, OGA, ASTP, and SAMHSA

Strategic Goal 1 supports HHS's work to deliver healthcare for the American people.

Figure 1: Strategic Goal 1: Performance Status of Measures by Objective, data as of August 2024



Strategic Goal 1 Discussion

HHS continues to increase access to quality healthcare and behavioral health services for all Americans. In FY 2023, HHS achieved the following:

- 16.3 million Americans signed up for 2023 individual market health insurance coverage through the *Patient Protection and Affordable Care Act* (PPACA) Exchanges during the 2023 Exchange Open Enrollment Period (OEP) (November 1, 2022 through January 15, 2023). This trend continued in 2024 when a record 21 million people selected health insurance coverage through the PPACA Exchanges.
- HRSA provided equitable healthcare to the nation's highest-need communities, with over 31.3 million patients served by health centers in 2023.
- HHS reduced healthcare costs through implementing the *Inflation Reduction Act of 2022*, which caps the price of insulin and increases CMS's bargaining power on prescription drugs. In August 2023, HHS announced the first 10 drugs covered under Part D selected for the first cycle of negotiations and reached agreements for all 10 drugs in August 2024.
- The Center for Medicare and Medicaid Innovation (CMMI) also announced several new innovative payment models. The Medicare Shared Savings Program Accountable Care Organizations (ACOs) also play an integral role in moving Medicare toward value-based payment models and person-centered care, with almost 11 million Medicare beneficiaries receiving care from a healthcare provider in a Shared Savings Program ACOs as of January 2023. These efforts drive innovative payment and service delivery models, which can reduce program expenditures for Medicare, Medicaid, and CHIP, while improving or preserving beneficiary health and quality of care.

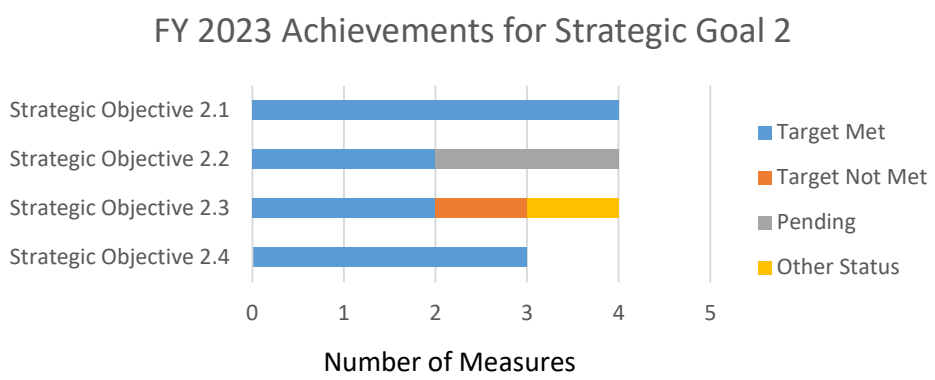
Challenges remain despite these achievements, including "Medicaid unwinding," when states restarted eligibility renewals for people with Medicaid following a pause during the COVID-19 pandemic. CMS has been taking steps to help people maintain coverage during this process, including extending a temporary special enrollment period to help people who are no longer eligible for Medicaid or CHIP transition to Exchange coverage in states using HealthCare.gov. Workforce challenges across the healthcare sector – including staffing needs in behavioral health fields, such as SUD care – also remain a core focus of HHS. Addressing these challenges is critical to providing better-quality healthcare and meeting the established performance targets.

Strategic Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes

Supporting Divisions – ACF, ACL, AHRQ, ATSDR, CDC, CMS, FDA, HRSA, IHS, NIH, ASFR, ASPE, ASPR, OASH, OCR, OGA, ASTP, and SAMHSA

Strategic Goal 2 supports HHS's work to deliver public health programs.

Figure 2: Strategic Goal 2: Performance Status of Measures by Objective, data as of August 2024



Strategic Goal 2 Discussion

HHS's Strategic Goal 2 includes a diverse array of public health programs, ranging from disaster and emergency response, infectious and non-communicable disease control, programs to prevent injury, illness and death, and the mitigation of environmental factors. In 2023, HHS achieved the following:

- ASPR's Biomedical Advanced Research and Development Authority (BARDA) program invests in the innovation, advanced research and development, FDA approval, acquisition, and manufacturing of medical countermeasures– including the vaccines, therapeutics, diagnostic tools, and devices needed to combat health security threats. As of September 2023, BARDA-supported products have achieved 84 FDA approvals, licensures, or clearances.
- NIH supported the development of six at-home COVID-19 tests, one of which addresses the accessibility needs of people with disabilities, one point-of-care (POC) COVID-19 test, and two POC multiplex tests for COVID-19 and flu.
- NIH-funded researchers advanced the preclinical development of three antiviral therapeutic candidates and supported two Phase 3 clinical studies that are evaluating antiviral therapeutics.
- IHS announced the E3 Vaccine Strategy - Every patient at Every encounter, Every recommended vaccine, when appropriate. IHS collaborated with key stakeholders to operationalize the National E3 Vaccine Strategy; efforts included implementing quality improvement cycles, encouraging innovation, and incentivizing efforts toward success and best practices developed in and for Indian Country. In 2023, IHS exceeded targets for the adult influenza vaccination rates.
- HHS continues to promote healthy behaviors, including national initiatives like CDC's Active People, Healthy Nation, which aims to help 27 million Americans become more physically active by 2027. The CDC-funded Walkability Action Institute has trained teams in 79 jurisdictions in 32 states and 2 territories.
- In 2023, the National Environmental and Health Outcome Tracking Network collected reports for 73 public health actions, with air quality, climate change, lead poisoning, cancer, and environmental justice as the most common environmental health topics addressed. From FY 2005 to FY 2023, state and local public health officials have used the Tracking Network to implement over 900 data-driven public health actions to save lives and prevent adverse health effects that are due to environmental exposures.

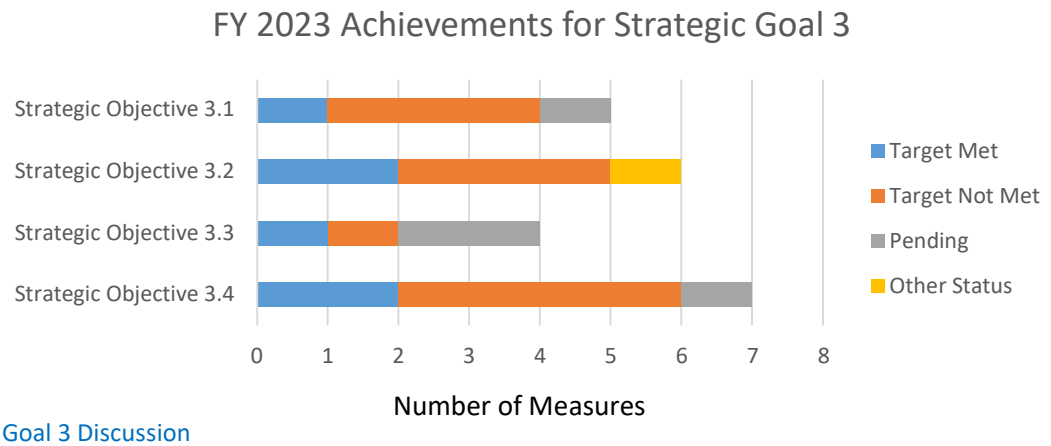
As extreme events like record-breaking heat and hurricanes become more intense due to climate change, HHS will continue to focus on prevention, preparedness, and mitigation to ensure our health systems are prepared.

Strategic Goal 3: Strengthen Social Well-Being, Equity, and Economic Resilience

Supporting Divisions – ACF, ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, NIH, ASFR, ASPE, OASH, OCR, OGA, and SAMHSA

Strategic Goal 3 supports HHS' work to deliver human services.

Figure 3: Strategic Goal 3: Performance Status of Measures by Objective, data as of August 2024



Strategic Goal 3 Discussion

HHS continues to protect and support children, families, people with disabilities, and older adults in an equitable way. In FY 2023, HHS achieved the following:

- The ACF Matching Grant program helps refugees and other Office of Refugee Resettlement (ORR) eligible populations overcome barriers and quickly find jobs. The intent is for refugees to become economically self-sufficient through employment within 240 days and without accessing cash assistance programs. In FY 2023, over 78 percent of participants achieved self-sufficiency within 240 days from the date of eligibility for the program.
- The ACF Transitional Living Program (TLP) continues to exceed outcome targets, with nearly 96 percent of youth living in safe and appropriate settings after exiting the program.
- Through SAMHSA's Project LAUNCH (Linking Actions to Unmet Needs in Children's Health), over 30,000 children between 0 – 8 years were screened for mental health or related interventions.
- Despite record high referrals in FY 2022 and FY 2023, successfully placed 99 percent of Unaccompanied Children (UC) referred by the Department of Homeland Security into care provider facilities within 24 hours of referral in both FY 2022 and FY 2023.
- CDC's Preventing Adverse Childhood Experiences Data to Action initiative helps ensure states and intrastate partners have access to the best available evidence for Adverse Child Experiences prevention and response. In FY 2023, funded recipients were implementing 15 prevention and response strategies.
- In 2023, IHS created a medical forensic guidebook that includes access to validated, evidence-based screening tools for providers and educational information related to domestic and intimate partner violence. In FY 2024, the IHS Domestic Violence Prevention (DVP) program grantees entered the third year of a 5-year funding cycle. Thirty-seven projects focus on culturally appropriate, evidence-based and practice-based models of prevention within the community.
- In FY 2023, the number of incoming signals to the National Human Trafficking Hotline (NHTH) from potential victims and survivors fell by 21 percent. Through engagement with stakeholders and ongoing performance monitoring, the Office on Trafficking in Persons (OTIP) has identified opportunities to strengthen the hotline's queuing system to better elevate signals from potential victims as the total number of signals to the hotline increases overall.

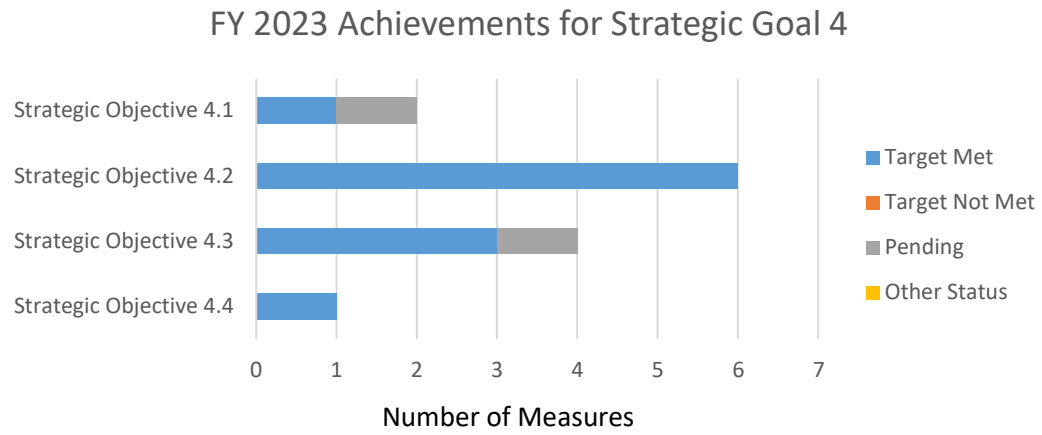
HHS will continue to invest in strategies to expand access to high-quality services and resources in order to achieve performance targets. Programs in Strategic Goal 3 face challenges such as ORR managing fluctuating numbers of new arrivals. The National Domestic Violence Hotline and NHTH similarly experience spikes in activity, which can impact their overall performance.

Strategic Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All

Supporting Divisions – All HHS divisions are working to achieve Strategic Goal 4

Strategic Goal 4 supports HHS's work in research and scientific endeavor.

Figure 4: Strategic Goal 4: Performance Status of Measures by Objective, data as of August 2024



Strategic Goal 4 Discussion

HHS continues to improve program design, scientific discovery, and data evaluation. In FY 2023, HHS achieved the following:

- HHS continues to lead significant research at the forefront of pressing health concerns. In FY 2023, NIH-funded investigators leveraged natural language processing and informatics to build and pilot test the Rosie the Chatbot mobile app. The investigators assessed the application's ability to provide information that meets the maternal health and infant care needs of racial and ethnic minority mothers who experience health disparities.
- NIH and FDA met or exceeded targets to support the scientific workforce pipeline though a variety of undergraduate, trainee, and fellowship programs. NIH-funded predoctoral trainees and fellows were 15 percentage points more likely to remain active in research than non-NIH trainees and fellows. FDA uses various strategies to attract and retain fellows, such as showcasing fellows' research at FDA's Annual Student Research Day. FDA is also working to streamline the hiring process to convert fellows to employees, leading to a 55 percent retention rate.
- HRSA's Rural Health Research Center Program funds eight core research centers which conducted and disseminated 81 research reports, including policy briefs. These publications include studies examining rural hospital finance, maternal health, post-acute care utilization, the extent and coverage of the Program of All-Inclusive Care for the Elderly (PACE) on rural communities and the impacts of insurance coverage changes among topic areas.
- CDC's National Center for Healthcare Statistics saw 100 percent of federal power users who rated the online data system report data quality as "good" or "excellent"– reflecting an increase from its 2022 performance and a turnaround in a focus area for improvement.
- In FY 2023, IHS supported over 300 Tribal Epidemiology Center (TEC) sponsored trainings and technical assistance to Tribes and Tribal Organizations. Additionally, the TEC awardees coordinated and authored

a special supplemental issue to the journal Public Health Reports, "Public Health Matters: Insights From Tribal Epidemiology Centers." The TECs provided examples of their best practice work in a tribal setting, described data collection activities, outlined their methods for demonstrating the value of TEC collaboration networks, and brought attention to data access issues and gaps in the current understanding of American Indian/Alaska Native health disparity surveillance.

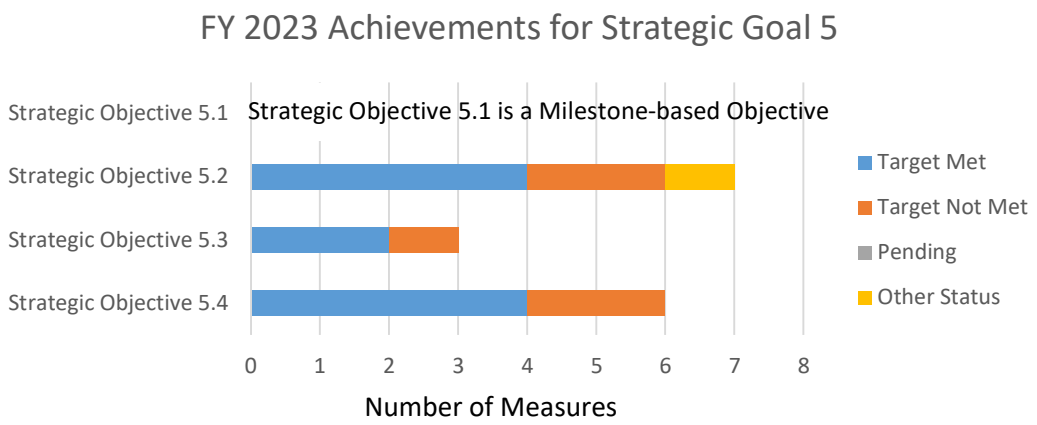
While HHS has shown great success in Strategic Goal 4, OpDivs and programs continue to stress the importance of evidence-based program design, the research enterprise and scientific workforce development, and the use of data to inform decision-making.

Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability

Supporting Divisions – All HHS divisions are working to achieve Strategic Goal 5

Strategic Goal 5 supports HHS's management and good governance objectives.

Figure 5: Strategic Goal 5: Performance Status of Measures by Objective, data as of August 2024



Strategic Goal 5 Discussion

In FY 2023, HHS achieved the following:

- HHS closed out five APGs including Child Well-being, Emergency Preparedness, Equity, and Maternal Health. The Department revised and extended an APG on Behavioral Health and implemented a new APG on CX for the FY 2024 – 2025 APG cycle.
- CMS continues to pursue program integrity and combat fraud. CMS fee-for-service, Medicaid, and CHIP programs have developed corrective actions for specific service areas with high improper payment estimates, including skilled nursing facilities (SNF), hospital outpatient, hospice, and inpatient rehabilitation facilities. Many of CMS's corrective actions center around prior authorization, medical review, and targeted probe and education efforts. CMS also uses automation, billing reviews, and the fraud prevention system to address improper payments. In addition, CMS conducts eligibility determination audits in high-risk states, provides training and support to state Medicaid program integrity officials through the Medicaid Integrity Institute, and provides resources and guidance to support states' provider enrollment processes.
- In FY 2023, HHS started an Employee Engagement Initiative aimed at strengthening the connections HHS employees feel to their work and to the organization. The impact of this initiative is measured in the annual Federal Employee Viewpoint Survey.
- HHS trains and educates its personnel to reduce the likelihood of staff mistaking phishing email attempts for legitimate communications through a combination of training, education, and tools.

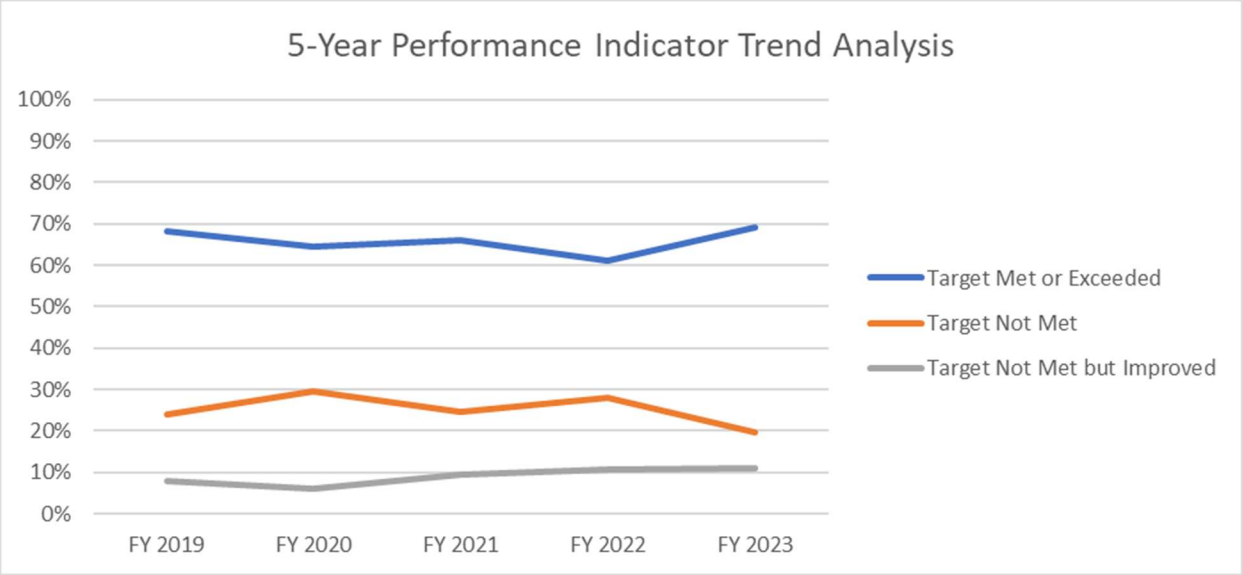
Performance Goals, Objectives, and Results

HHS is committed to achieving the strategic management goals outlined in the HHS Strategic Plan FY 2022 – 2026. Challenges stem from changes to improper payment methodology, pursuing high ratings in Federal Employee Viewpoint Survey results, and HHS facilities maintenance and repairs. Missed targets in Strategic Goal 5 are attributable to one-time events which impeded overall performance or to the practice of setting stretch goals to drive performance.

Congressional Justification Trends

Figure 6 is a summary chart for reported performance results through FY 2023, the most recent results available. The following chart includes both measures in the HHS Strategic Plan but also those which appear only in budget materials. HHS advises OpDivs and StaffDivs to set realistic and achievable stretch targets. The Department strives in aggregate to achieve a rate of 70 – 75 percent of targets met and work diligently toward improving other results. The Department has increased review and oversight of target-setting practices.

Figure 6: 5-Year Performance Indicator Trend Analysis of Reported Data, as of September 18, 2024

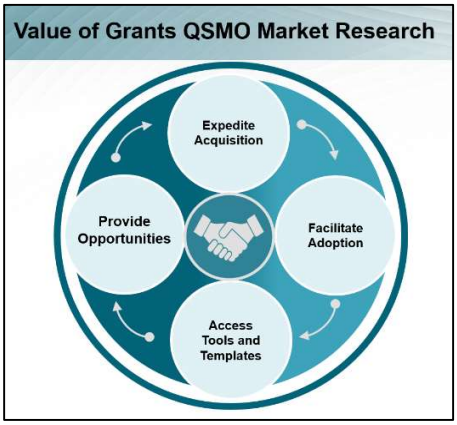


Funding represents one of many factors that may influence performance results. More detailed information on HHS program performance and funding can be found on the HHS Budget and Performance webpage. For select performance information aligned to the HHS Strategic Plan, refer to the FY 2025 Annual Performance Plan and Report. Final FY 2024 performance results and other updates will be published in early calendar year (CY) 2025.

Grants Quality Service Management Office (Grants QSMO)

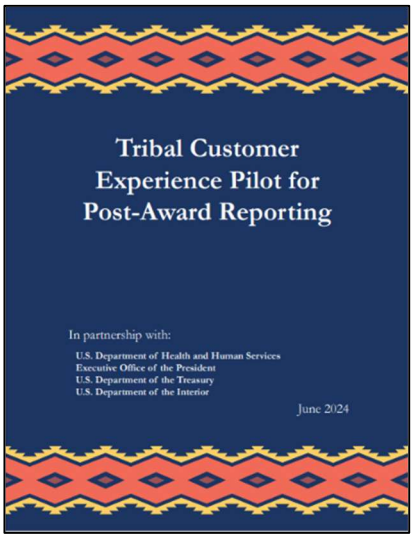
Authorized by OMB Memoranda M-19-16, *Centralized Mission Support Capabilities for the Federal Government*, and OMB's designation of the Grants QSMO at HHS, the Grants QSMO is responsible for establishing a marketplace of quality shared solutions/services, governing the long-term sustainability of the solutions/services, and driving implementation of grants data standards. The Grants QSMO's vision seeks to 1) ease burden and drive efficiencies through standardization and modernization, 2) leverage data as a strategic asset through standard adoptions and, 3) respond to customer needs through continuous engagement of applicants, recipients, and providers. OMB continues to support the Grants QSMO's work with four additional memorandums and inclusion in the Title 2 Code of Federal Regulations 1.305 guidance updates, requiring agencies to coordinate with the Grants QSMO. In 2023, the Grants QSMO's role within the broader grants community governance structure was highlighted in OMB Memoranda M-23-19, which created the Council on Federal Financial Assistance (COFFA) as a single leadership forum composed of interagency council members to inform federal financial assistance policy, oversight and technology activities, including strategic direction, policy, recommendations, and priorities for grants-related activities.

A primary objective of the Grants QSMO is to provide a marketplace of grants management solutions and services through the Grants QSMO Marketplace. The Grants QSMO Marketplace provides Federal Awarding Agencies with information to support and inform decisions on adopting shared solutions/services across the entire grant's lifecycle. Since its inception, the Grants QSMO has identified year-over-year a significant demand for both Federal shared service providers and a commercial marketplace, providing agencies with options for high-quality grants management systems and solutions. Since FY 2023, five agencies (U.S. Department of Commerce, U.S. Department of the Interior, U.S. Department of Labor, U.S. Small Business Administration, and Social Security Administration) have transitioned to a Grants QSMO Federal Shared Service Provider.



In FY 2024, the Grants QSMO, in concert with the COFFA, continued to refine and partner on a federal-wide strategy to improve grants mission delivery across the government through new Grants IT market research. In March 2024, the Grants QSMO released a Request for Information to better understand the commercial grants IT solution ecosystem and to learn from industry providers how best to operationalize the commercial side of the Grants QSMO Marketplace. This need was driven by significant agency demand for award management shared services, limited capacity of current Federal shared service providers, and an unserved market for smaller agencies. The market research resulted in six Grants QSMO verified commercial solutions further expanding robust marketplace options for customer agencies. This new information was used to update an ordering guide and Catalog of Market Research on General Services Administration's (GSA) Acquisition Gateway. The Grants QSMO Acquisition Gateway provides access to quality tools, checklists, and sample acquisition documents to expedite the acquisition process to access quality IT solutions. Through the Grants QSMO Acquisition Gateway, the Grants Marketplace provides choices appropriate for different federal customers (i.e., small, medium, and large agencies), avoiding a "one size fits all" approach. By leveraging Grants QSMO market research, which includes alignment to government-wide standards as well as contract details, system capabilities, and system demos, the Grants QSMO streamlined the acquisition process to better support agencies' initial acquisition planning efforts. These agencies include AmeriCorps, Inter-American Fund, Library of Congress, Northern Border Regional Commission, and the Department of Veterans Affairs.

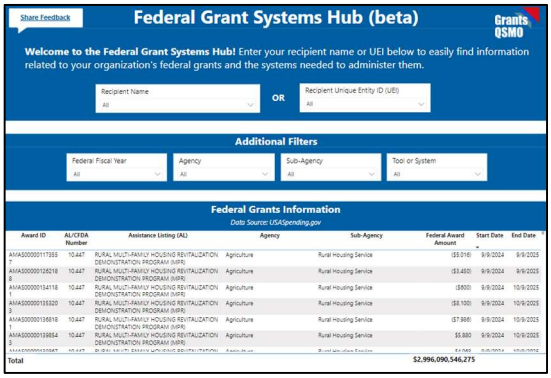
Performance Goals, Objectives, and Results



The Grants QSMO continued to focus on transparency in 2024, ensuring federal agencies select appropriate solutions for each agency's specialized needs by expanding the information available to our federal awarding agency customers. The Grants QSMO partnered with shared service providers to develop and promote *Buying Insights* and *Value Insights,* an initiative providing information on benefits of shared services value, available capabilities and specific details on cost methodology and technical interfaces.

In support of the President's Management Agenda and HHS agency goal for customer experience, the HHS Office of Grants (led by Grants QSMO) partnered with the Executive Office of the President, Department of the Treasury and Department of the Interior to create a cross-agency team to develop and test customer-focused improvements to underserved areas. Feedback from tribal recipients indicated the resources required for grant reporting often outweighed the benefits of the funding. In particular, recipients from small rural communities reported significant obstacles, including the loss of key administrative personnel due to the pandemic and limited broadband access. In response, the cross-agency team conducted human-centered design research and identified five key needs of Tribal grant recipients including (1) Skilled Staff, (2) Seamless Transitions, (3) Offline Accommodations, (4) Easy Portal Access, and (5) Simplified Reporting.

The project launched four pilot solutions to meet these needs, including the Federal Grant Systems Hub (beta) developed by the Grants QSMO. This pioneering resource aims to create a more streamlined user experience by centralizing access to organization-specific grants data and management systems in a user-friendly dashboard, addressing the fragmentation prevalent in the federal grants landscape. The Hub combines *USAspending* data and sub-agency grant systems data to display 28 unique data points, with the ability to view the information using 6 different filters for further insights. One recipient gave feedback noting, "This is great for someone new. If I were to transition away, I would make sure my replacement had this. It shows everything you need in one place."

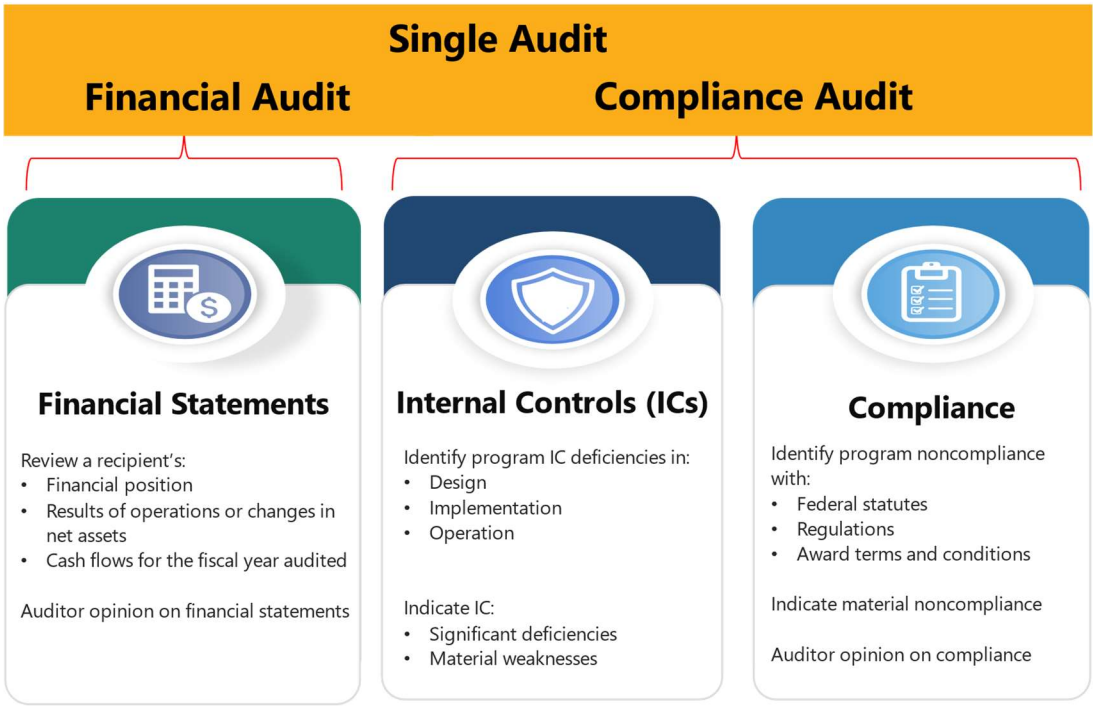


One of the biggest findings from the Tribal CX project revealed the challenges faced by tribal recipients closely align with those encountered by grant recipients at large. Therefore, modernization efforts aimed at improving the fragmented grants management landscape, building capacity, and enhancing systems access will benefit all recipients. Key findings, insights, and opportunities were published in a widely distributed final report that supports improved customer experience solutions government-wide.

Single Audit

HHS is the largest provider of Federal financial assistance, and quality single audits and safeguards these Federal funds for their intended purposes through the performance of single audits. Under Title 2 Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, and the *Single Audit Act of 1984* (as amended by the *Single Audit Act Amendments of 1996*), a non-Federal entity (award recipient) that expends $750,000 ($1,000,000 starting in FY 2025) or more of Federal financial assistance during its fiscal year must have a single audit conducted. As shown in **Figure 7**, a single audit includes a financial audit and a compliance audit.

Figure 7: Single Audit Components and Testing



The single audit is one of the primary means by which HHS monitors its award funding. Between FY 2020 and FY 2024, recipients of HHS award funding submitted on average 19,588 single audit reports per year, representing nearly half (46%) of the average yearly total submitted by all recipients of Federal award funding.

A single auditor selects a recipient's Federal program(s) for a compliance audit based on the amount of Federal awards expended, program risk level, and other considerations. As part of a compliance audit, single auditors will issue audit findings for deficiencies in internal control and noncompliance with Federal program requirements. The audit findings may relate to allowable costs or activities, eligibility, timely submission of reports, or other compliance areas. To ensure recipients correct deficiencies in a timely manner, the *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* requires that Federal awarding agencies issue management decisions on audit findings within six months of acceptance of the single audit report by the Federal Audit Clearinghouse.

Looking Ahead to 2025

In 2025, HHS will address important healthcare, public health, human services, and research issues that impact all Americans through the strategic direction set forth in the HHS Strategic Plan FY 2022-2026. HHS will also update its Strategic Plan in 2025 to align with the priorities of the next presidential administration.

HHS Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare	
	HHS works to protect and strengthen equitable access to high-quality and affordable healthcare. Increasing choice, affordability, and enrollment in high-quality healthcare coverage is a focus of the Department's efforts, in addition to reducing costs, improving quality of healthcare services, and ensuring access to safe medical devices and drugs. HHS also works to expand equitable access to comprehensive, community-based, innovative, and culturally and linguistically appropriate healthcare services while addressing social determinants of health. The Department is driving the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and SUD treatment and recovery services for individuals and families. HHS also bolsters the health workforce to ensure delivery of quality services and care. HHS will continue progressing across healthcare priority areas, including: • Behavioral Health Integration • Critical Medical Products Supply Chain Resilience • Drug Pricing • Health Systems Resilience and Sustainability • Healthcare Workforce • Maternal and Reproductive Health • Nondiscrimination and Enforcement of Civil Rights and Privacy Laws for Patients Accessing Healthcare • Nursing Home Quality and Safety

Looking Ahead to 2025

HHS Strategic Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes	
	HHS is dedicated to safeguarding and improving health conditions and health outcomes for everyone. The Department improves capabilities to predict, prevent, prepare for, respond to, and recover from disasters, public health and medical emergencies, and threats domestically and abroad. The Department protects individuals, families, and communities from infectious disease and prevents non-communicable disease through the development and equitable delivery of effective, innovative, readily available treatments, therapeutics, medical devices, and vaccines. HHS enhances the promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death. The Department also mitigates the impacts of environmental factors, including climate change, on health outcomes. HHS will continue progressing across public health priority areas, including: • Climate Change and Improving Health Sector Readiness • Combating Antibiotic-Resistant Bacteria • Overdose Prevention • Public Health Emergency Preparedness and Response

Did You Know?

HHS established the Department's first-ever HHS DEIA Strategic Plan in March 2022 under Executive Order 14035, titled "Diversity, Equity, Inclusion, and Accessibility (DEIA) in the Federal Workforce." Over the past two fiscal years, HHS has successfully implemented numerous initiatives and projects to elevate and embed DEIA at HHS, including the DEIA Change Stories campaign. This campaign shared the personal journeys of HHS leaders, reaching nearly 90,000 people and highlighting the impact of their experiences in strengthening personal commitment to DEIA. These efforts are designed to foster transparency, authenticity, and promote inclusion and belonging, inspiring progress across the organization.

Looking Ahead to 2025

HHS Strategic Goal 3: Strengthen Social Well Being, Equity, and Economic Resilience	
	HHS works to strengthen the economic and social well-being of Americans across their lifespan. HHS provides effective and innovative pathways leading to equitable economic success for all individuals and families. The Department strengthens early childhood development and expands opportunities to help children and youth thrive equitably within their families and communities. HHS expands access to high-quality services and resources for older adults and people with disabilities, and their caregivers, to support increased independence and quality of life. HHS also increases safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence. HHS will continue progressing across human services priority areas, including: • Child Welfare • Economic Mobility • Health-Related Social Needs • Information, Services, or Benefits from HHS Programs and Activities for Individuals with Limited English Proficiency • Long-Term Care Workforce

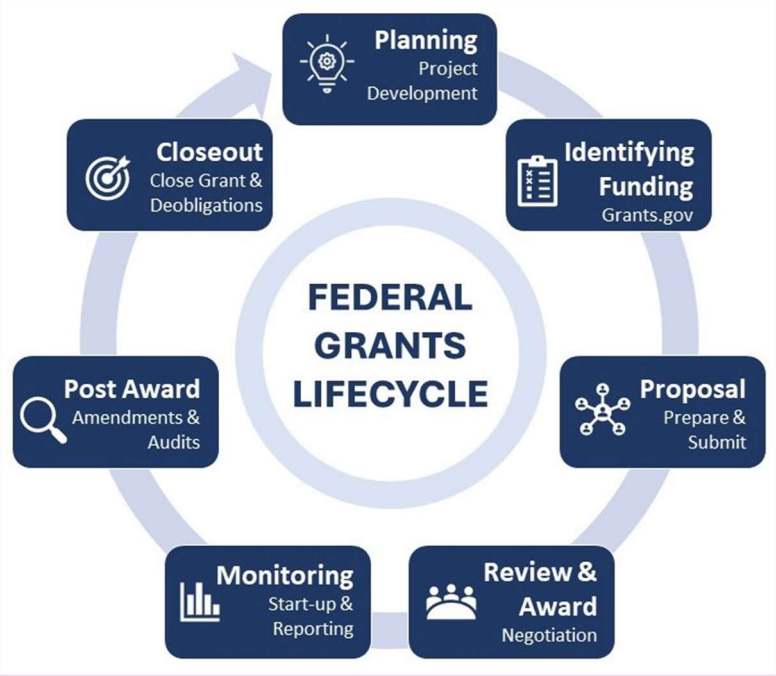
HHS Strategic Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All	
	HHS is dedicated to restoring trust and accelerating advancements in science and research. The Department is prioritizing science, evidence, and inclusion to improve the design, delivery, and outcomes of HHS programs. The Department is investing in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs. Strengthening surveillance, epidemiology, and laboratory capacity is another major focus to better understand and equitably address diseases and conditions. HHS is also increasing evidence-based knowledge through improved data collection, use, and evaluation efforts to achieve better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience. HHS will continue progressing across data, evidence, and evaluation priority areas, including: • Cancer Moonshot • Clinical Research Diversity • Data Capacity for Patient-Centered Outcomes Research • Developing Evidence-Building Capacity • Guidance to Improve Data Usability • Scientific Integrity

Looking Ahead to 2025

HHS Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability	
	HHS is dedicated to advancing strategic management across the Department to build trust, transparency, and accountability. A major focus of the Department is promoting effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices. HHS sustains strong financial stewardship of resources to foster prudent use of resources, accountability, and public trust. HHS works to uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission. The Department also ensures the security of HHS facilities, technology, data, and information, while advancing environment-friendly practices. HHS will continue progressing across management priority areas, including: • Advance Customer Experience • Improve Strategic Management Coordination • Mitigate Future Climate Change Risks

Did You Know?

HHS provides federal financial assistance directly to states, territories, tribes, and educational and community organizations that disburse payments to eligible private entities and individual recipients. The Federal financial assistance process follows a streamlined lifecycle that includes pre-award activities (i.e., project development, identifying and creating a funding opportunity), application review and award, award monitoring and oversight through single audits and compliance reviews, and successful closeout processes such as administrative closeout and award deobligations, as deemed applicable. Refer to the HHS Grant Process website for more information.



Analysis of Systems, Legal Compliance, and Internal Control

Systems

HHS Financial Management Systems Environment

HHS strives to improve the financial management systems environment for HHS's diverse portfolio of mission-oriented programs and business operations.

The primary objectives of the financial management systems environment are to:

- Process financial transactions efficiently in support of program activities and HHS's mission;
- Provide complete and accurate financial information for decision-making;
- Improve data integrity;
- Strengthen internal controls; and
- Mitigate risk

The HHS financial management systems environment provides the foundation to manage approximately $2.9 trillion in budgetary resources entrusted to the Department in FY 2024. This environment supports and delivers efficient and timely disbursement of funds critical to providing effective health and human services to all Americans. Additionally, HHS's robust financial management systems environment plays a crucial role in providing federal contract, grant, and other financial assistance data to USAspending.gov, which presents clear, accurate, and timely awards information while providing transparency and accountability to the American public.

The HHS financial management systems environment, detailed in **Figure 8**, consists of two Department-wide reporting systems and a core financial system. The two reporting systems within the HHS financial environment facilitate financial statement compilation, data-driven business decisions, and managerial reporting. The core financial system's three instances integrate with 100+ mission-support systems including external Government-wide systems, HHS enterprise systems, and OpDiv systems to create a robust financial management environment that supports HHS's diverse programs. The instances operate on the same commercial off-the-shelf platform to promote Department-wide data standardization. Together, these systems create the HHS financial management systems environment and fulfill HHS's financial accounting and reporting needs.

Did You Know?

Scientists at the National Institutes of Health (NIH) have uncovered a brain circuit in primates that rapidly detects faces. This newly discovered circuit explains how we're able to quickly detect and look at faces, even if they first show up in the peripheral visual field where visual acuity is poor. This circuit could be what spotlights faces to help the brain learn to recognize individuals and understand complex facial expressions, helping us acquire important social interaction skills."

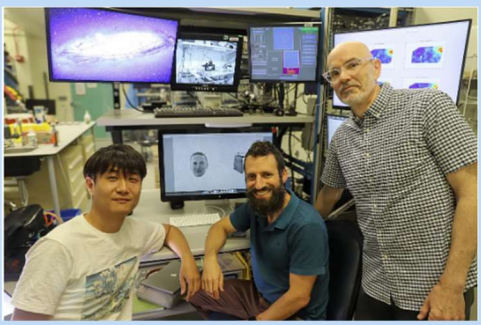
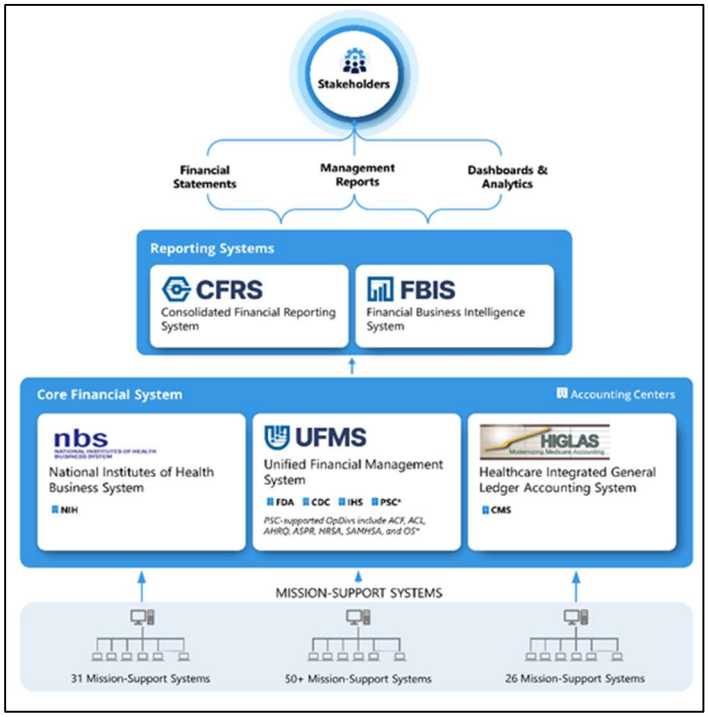


Figure 8: HHS Financial Management Systems Environment



HHS Financial Management Systems

Consolidated Financial Reporting System (CFRS) systematically consolidates information from the core financial system's three instances to generate Departmental quarterly and year-end consolidated financial statements on a consistent and timely basis while supporting HHS in meeting regulatory reporting requirements.

Financial Business Intelligence System (FBIS) retrieves, combines, consolidates, and reports data from the core financial system. Additionally, it provides end users with the functionality to analyze data and present actionable information, including metrics and key performance indicator dashboards with graphical displays, interactive reports, and ad-hoc reporting, providing valuable insights.

National Institutes of Health Business System (NBS) supports NIH's diverse biomedical research program, and business, financial, acquisition, and logistics requirements for 27 NIH Institutes and Centers. NBS also supports grant funding for more than 300,000 researchers at over 2,500 universities, medical schools, and other research institutions in every state and around the world (NIH.gov).

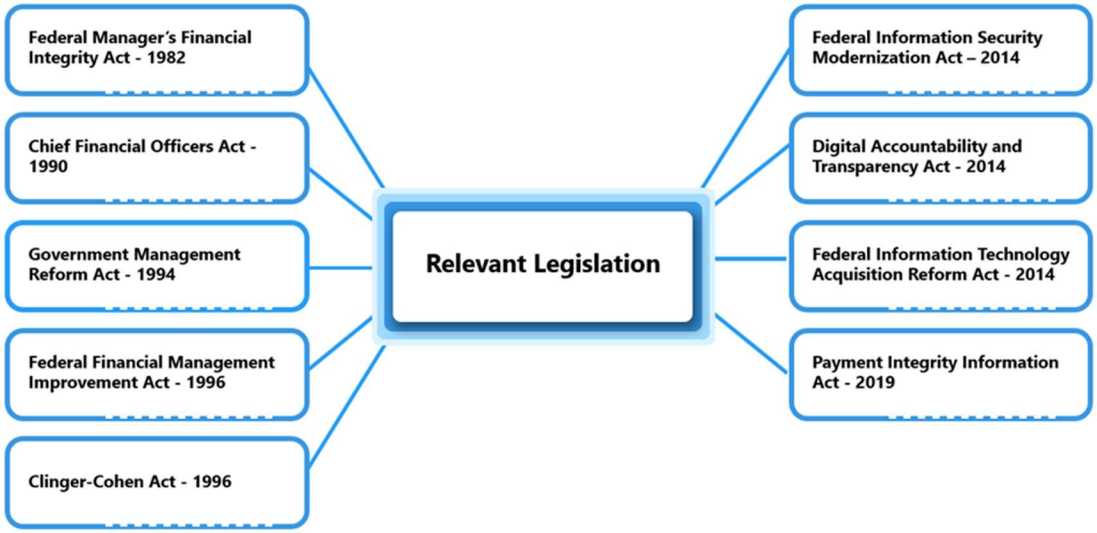
Unified Financial Management System (UFMS) integrates with over 50 mission-critical programs, businesses, and administrative systems to provide a secure, reliable, and highly available shared services financial management environment supporting CDC, FDA, IHS, and PSC. PSC provides shared-service accounting support for ACF, ACL, AHRQ, ASPR, HRSA, SAMHSA, and 14 StaffDivs within OS.

Healthcare Integrated General Ledger Accounting System (HIGLAS) processes an average of five million transactions daily and supports four lines of CMS business: Medicare fee-for-service, Medicare Secondary Payer, Federal Facilitated Exchange, and Administrative Program Accounting activities (CMS.gov).

Relevant Legislation

The HHS financial management systems environment must comply with all applicable federal laws and regulations included in **Figure 9**.

Figure 9: Relevant Legislation



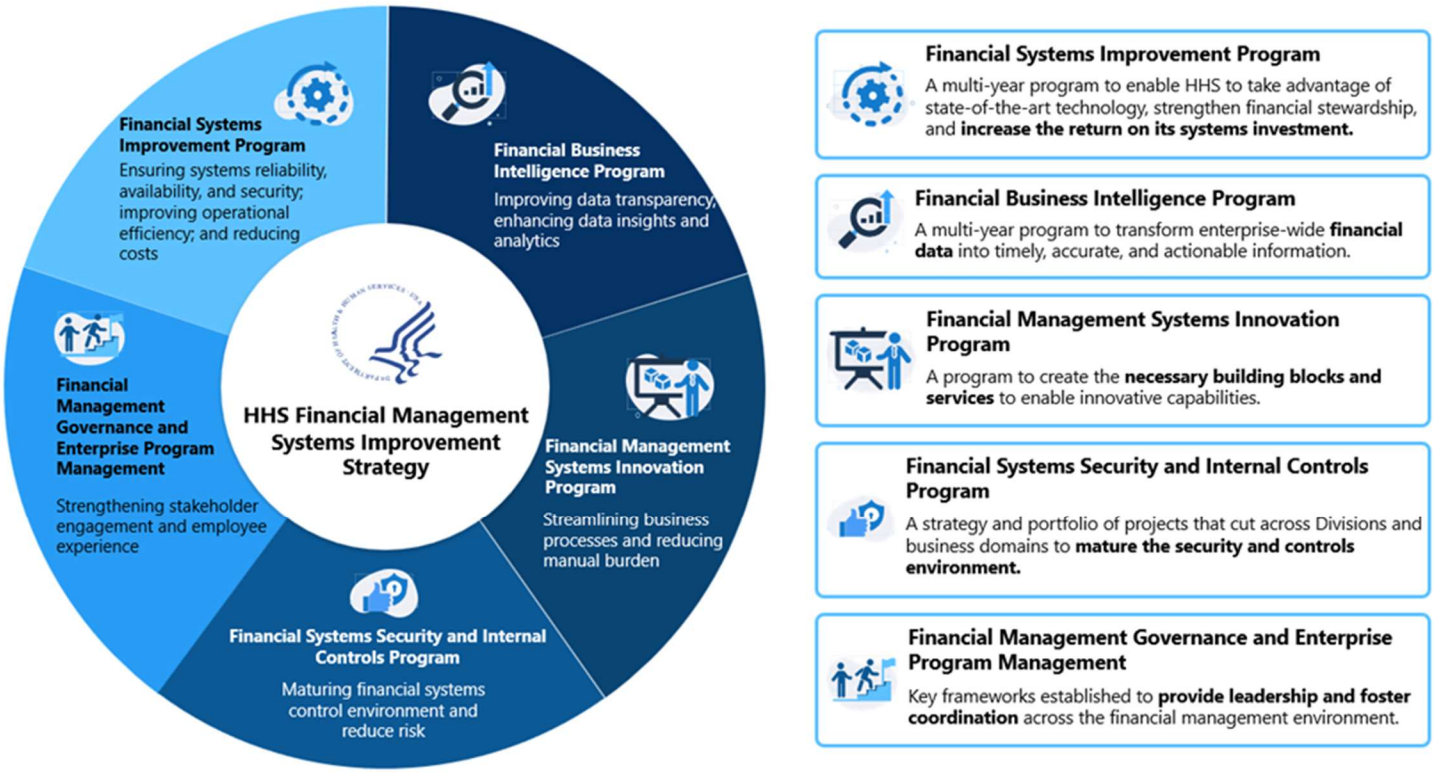
Financial Management Systems Improvement Strategy

Financial managers continue to face a rapidly changing financial management landscape with increasing demands for accountability and transparency, evolving federal mandates, emerging technologies, and increasing security threats while working to maximize the value of system investments. HHS has made significant strides in maturing the financial management systems environment, enabling HHS to proactively address these challenges.

HHS developed a robust financial management systems improvement strategy, summarized in **Figure 10**, resulting in the creation of five collaborative programs. Together, these programs establish a secure, reliable, and high-performing financial management systems environment to enable constant innovation and swiftly adapt to federal mandates while simultaneously enhancing operational efficiency and reducing costs. These five critical programs synergistically leverage state-of-the-art technology, strengthen financial stewardship, enhance data analytics capabilities, implement intelligent automation for streamlined business processes, bolster stakeholder engagement, and fortify security and internal controls.

HHS's unwavering commitment to progress and innovation empowers financial managers to navigate the dynamic financial landscape, overcome challenges, and seize opportunities. With a customer-centric approach, HHS ensures that each mission-critical project enhances the capabilities of the enterprise-wide financial management systems, delivering value to end users.

Figure 10: Financial Management Systems Improvement Strategy



1. Financial Systems Improvement Program

Through the Financial Systems Improvement Program (FSIP), HHS is actively pursuing multiple initiatives to generate efficiencies and improve the effectiveness of the financial management systems.

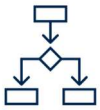
- HHS successfully deployed the first phase of U.S. Department of the Treasury's **Government Invoicing (G-Invoicing)** solution for well-defined intra-governmental buy/sell transactions (IGTs) in October 2022. The G-Invoicing solution not only aims to meet the Government-wide mandate but also strives to enhance the quality and reliability of IGT data, promote transparency among federal agencies, improve accounting and reporting accuracy, and effectively support efforts to resolve a long-standing material weakness across the government.

  Since its introduction, HHS has continued in its efforts to enhance the G-Invoicing solution through the implementation of complex IGT processes, the incorporation of additional functionality, and the facilitation of user adoption. In FY 2024 alone, HHS processed 180 percent more orders through the system compared with the previous year. Furthermore, HHS's deployment of G-Invoicing Service and Supply Fund and Seller-Facilitated Order functionality in October 2023 introduced new features that allow a broader range of users to create orders. HHS's continued adoption and maturation of G-Invoicing underscores its commitment to modernizing financial processes and delivering tangible benefits to both the organization and the wider government landscape.

- HHS successfully launched **Cloud Financial Operations (FinOps)** in 2024, revolutionizing HHS's financial operations and optimizing spending. Following the successful migration of HHS financial systems to the cloud, FinOps was introduced to empower HHS to make data-driven decisions when managing cloud resources. The migration to the cloud introduced access to a wide range of capabilities and presented

numerous opportunities to leverage state-of-the-art tools and technology. However, it also brought forth significant challenges in terms of cost control and resource utilization efficiency.

The FinOps initiative plays a crucial role in optimizing HHS's cloud resources and associated spending. It streamlines processes, ensures accurate cost allocation, and facilitates efficient resource utilization, enhancing HHS's financial management effectiveness through data-driven decision-making. Through this forward-thinking approach, HHS continues to pave the way for efficient and effective cloud resource management, ultimately driving positive outcomes for the entire organization.



- HHS successfully implemented modern **Development, Security, and Operations (DevSecOps)** processes and tools within the financial systems environment. This implementation has led to accelerated customer service, enhanced product quality, streamlined operations, strengthened security and internal controls, and increased auditability. The integration of DevSecOps has enabled the early identification and resolution of issues, resulting in the delivery of high-quality end products to the end-users. Furthermore, the implementation of DevSecOps has streamlined financial system operations and the deployment of solutions, significantly reducing the time for deployment efforts while maximizing productivity.

- HHS successfully expanded the financial systems cloud environment and migrated NBS to **Oracle Cloud Infrastructure (OCI)** in March 2024. The addition of the NBS technical portfolio to the cloud environment expands HHS's financial systems modernization effort, the largest across the federal government. The NBS migration further positions HHS for future success, enabling HHS to establish a strong foundation for the next generation of financial systems, cloud-enabled data analytics, artificial intelligence capabilities, and a more scalable, agile, and cost-effective environment.

- HHS strengthened the overall financial systems environment, resulting in significantly improved security, reliability, and availability of financial systems. Throughout FY 2024 the financial management portfolio systems – CFRS, FBIS, and UFMS – were available 99.99 percent of the time, as measured by the hosting provider.

2. Financial Business Intelligence Program

The Financial Business Intelligence Program (FBIP) provides approximately 2,000 users within the HHS financial management community the ability to analyze financial information and transform data into actionable insights for strategic and tactical decision-making through FBIS. HHS has made progress on its commitment to facilitate improved stewardship and decision-making in FY 2024 through a dedicated effort to bolster FBIS's capabilities and adoption.

- HHS provided insight-driven reports and dashboards for financial management systems and projects supported by change management efforts to increase awareness and adoption of HHS systems adherence to federal mandates. As a result, the financial management community has access to new insights, along with tools to execute financial management responsibilities effectively and efficiently, while remaining federally compliant.

- HHS has successfully implemented **seamless integration of Department-wide financial data** from the core financial systems UFMS and NBS within the business intelligence system. This integration allows for a unified view of data from disparate financial system instances, resulting in significant improvements

in decision-making capabilities, data analytics, the discovery of valuable insights, productivity optimization, and the delivery of an exceptional customer experience.

- HHS launched the **User Experience Modernization (UEM)** project in 2023 based on feedback from more than 300 users from 13 OpDivs. UEM included the launch of the Office of Financial Systems Policy and Oversight Hub, FBIS Gateway, Procure-to-Pay Dashboard, and FBIS University Learning Center. As a result of UEM, FBIS users now have increased ease of access to the system, strengthened navigation capabilities, on-demand training, and improved dashboards and reports.

Building on the UEM foundation, the FY 2024 **FBIS Analytics Modernization (FAM)** project featured the launch of the **FBIS Assistant**, a virtual artificial intelligence program. The FBIS Assistant went live in September 2024 and supports users by providing answers to system-related questions and finding and navigating to relevant FBIS reports, dashboards, training materials, and help desk information. The program reduces the overall time needed to locate system information and increases FBIS adoption, aligning with the HHS objective to streamline FBIS navigation and improve user experience.

- HHS has enhanced the **FBIS University Learning Center**, which now offers a wide range of over 70 training resources. These resources include interactive trainings, job aids, bite-sized videos, and tutorials, empowering users to learn at their own pace and make informed decisions using financial data. Additionally, HHS has delivered more than 25 instructor-led training sessions, with approximately 90 attendees per session, to promote user adoption and engagement.

3. Financial Management Systems Innovation Program

HHS continues to undertake various initiatives to capitalize on technological advances and enable innovative capabilities to streamline business processes and reduce manual burden.

- HHS continued to manage the **HHS Automation-as-a-Service (HAaaS)** initiative to use Robotic & Intelligent Automation (R&IA) to improve financial management processes by reducing manual burden, improving efficiency and quality, and increasing capacity for the HHS workforce to accomplish higher value tasks.

In FY 2024, **Robotics Process Automation (RPA)** implemented 20 automations to improve end-user business processes and bring efficiencies into financial system operations, saving more than 9,000 manual hours for HHS. The automations allowed HHS personnel to focus on higher-value tasks, reducing the risk of human error, and improving compliance and security controls.

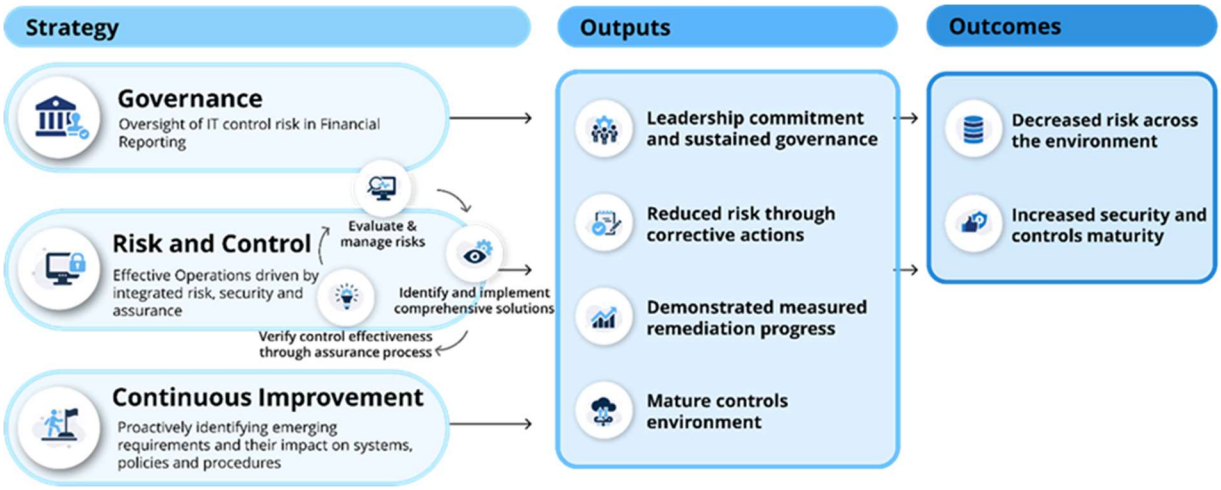
4. Financial Systems Security and Internal Controls Program

The reliability, availability, and security of HHS's financial systems are of utmost importance. HHS is firmly committed to advancing its department-wide comprehensive strategy aimed at maturing the Financial Systems Control Environment (FSCE) and reducing risk. The strategy, illustrated in **Figure 11**, serves as a solid foundation for effective governance and oversight. It not only guides collective actions across the Department to address underlying issues and mitigate risks but also facilitates proactive measures to continuously improve and mature the overall financial systems environment. These strategic initiatives and operational activities pave the way toward successfully achieving desired strategic outputs and outcomes.

HHS FSCE continues to operate with no material weakness since FY 2018 and maintains substantial compliance with *Federal Financial Management Integrity Act of 1996* (FFMIA). Furthermore, FSCE has successfully remediated several high-risk findings identified by external auditors that were associated with the significant deficiency. FSCE is actively working towards reducing the significant deficiency by FY 2025. In addition, HHS made significant

improvements by closing 75% of prior years' Federal Information System Controls Audit Manual (FISCAM) audit weaknesses, and overall FISCAM audit weaknesses have decreased 80% year after year since FY 2015. These achievements demonstrate HHS's unwavering commitment to maintaining a robust and secure financial systems control environment.

Figure 11: Financial Systems Control Environment Maturity Strategy



HHS prioritizes internal control governance to enhance oversight, establish standardized policies, implement security controls, and ensure timely communication with stakeholders at every level, including providing maturity progress reports to HHS governance boards and holding monthly meetings. The Department has made significant strides in strengthening internal control oversight by providing guidance and assistance to OpDivs in assessing financial management systems scope and associated risk. As a result, 44 financial core accounting and mixed systems were included in scope by OpDivs for the annual FFMIA compliance assessment. The assessment results demonstrated HHS's financial systems substantial compliance with FFMIA requirements. These efforts underscore HHS's commitment to maintaining the highest standards of integrity and ensuring the reliability of its financial systems.

Risk management and control activities serve as the foundation of HHS's Department-wide FSCE maturity strategy. These crucial activities ensure the seamless integration of risk, security, and assurance processes, thereby fostering effective operations. By implementing tactical risk evaluations, comprehensive corrective action planning, and diligent monitoring and verification of risk mitigation, management maintains control over the FSCE. To evaluate IT control risks within the FSCE, HHS has established an annual Management Assessment Framework (MAF) process. This process employs objective and quantifiable risk measurement criteria, enabling management to assess the Department's progress in achieving its strategic objective of a mature FSCE that effectively mitigates risk. The FY 2024 MAF assessment determined that 93 percent of the controls tested were effective, with no material weaknesses. By continuously evaluating and improving the FSCE, HHS proactively mitigates risks and strives toward a more mature and resilient control environment.

HHS continues to improve its security posture by modernizing financial systems, monitoring emerging technologies, and providing risk management guidance and best practices through collaboration among CFO, Chief Information Officer (CIO), and Chief Information Security Officer (CISO) communities. By continuously modernizing its financial systems, HHS ensures the financial systems are equipped with the latest security measures and technologies. Additionally, by closely monitoring emerging technologies, HHS stays ahead of potential security risks, enabling timely response and mitigation. HHS organized its seventh annual Financial Systems Audit, Internal Control, and Risk Management Summit in May 2024. This Summit recognized the collective efforts of teams and individuals across OpDivs in advancing FSCE maturity. With over 130 attendees from diverse communities, including CFO, CIO, and CISO, the Summit celebrated achievements, shared visions, strategies, and emerging technologies, and fostered collaboration

discussions. Department CFO and CISO leadership have applauded the Summit as a vital platform for sharing best practices and driving Department-wide IT security and control maturity.

5. Financial Management Governance and Enterprise Program Management

HHS institutionalized key frameworks to increase stakeholder engagement at all levels in the decision-making process to help establish a common direction and drive enterprise-wide priorities. To guide Department-wide initiatives that have a financial management impact, HHS established the Financial Management Governance Board (FGB). Initialized in 2013, the FGB serves as one voice for the financial management community; it is an executive-level forum to address enterprise-wide concerns related to financial management policies and procedures, financial data, financial systems, and technology impacting the Department, OpDivs, and StaffDivs. The FGB's goals complement the Department's strategic goals, as illustrated in **Figure 12**.

Figure 12: Financial Management Governance and Enterprise Program Management Overview

In FY 2024, the FGB oversaw and guided major projects and initiatives including Treasury's Financial Management QSMO initiative, Grants QSMO, Cybersecurity QSMO and the HR QSMO, as well as E-Gov Travel Service Next Implementation. These projects and initiatives meet federal mandates, enhance data quality, improve cost accountability, align HHS financial management services with government-wide standards, and provide guidance and services to other government grant making agencies. The FGB structure allows for its working groups to guide HHS financial policies, provide unified data standards and accounting treatment, coordinate audits throughout the Department, and manage risks associated with financial systems.

Enterprise Program Management provides a sustaining framework for the HHS financial management community stakeholders, while strengthening coordination, collaboration, and shared responsibilities related to programs and projects across the Department. In FY 2024, the Enterprise Program Management Office (EPMO) continued its efforts to transform project implementation and execution by refreshing its methodology for Strategic Templates and Resource Tools (START). This methodology provides a standardized framework to manage all project types and sizes, delivering training for Integrated Baseline Review (IBR) and Risk Management process areas to align with Department and industry standards.

The EPMO also conducted its Annual Lessons Learned exercise with key stakeholders to gain insight into successes and challenges on FY 2023 projects for continual process improvement. As the Department's business needs evolve, the EPMO continues to mature and support ongoing collaboration and coordination across the financial systems community and modernization initiatives.

Legal Compliance

Antideficiency Act

The *Antideficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, obligating before funds are available, and from accepting unauthorized voluntary services. ADA reports can be found on U.S. Government Accountability Office (GAO) - ADA Resources.

HHS management is proactive in preventing ADA violations. The Administrative Control of Funds policy, as required by U.S. Code, Title 31, *Money and Finance*, Section 1514, "Administrative Division of Apportionments," states HHS's guidelines for budget execution, specifying basic fund control principles and concepts. HHS is currently reviewing 3 potential issues and remains fully committed to resolving these matters appropriately and complying with all aspects of the law.

Bipartisan Infrastructure Law

The *Bipartisan Infrastructure Law* (BIL), as enacted in the *Infrastructure Investment and Jobs Act,* was signed on November 15, 2021. BIL aims to rebuild America's roads, bridges, and railways; expand access to clean drinking water; ensure every American has access to high-speed internet; tackle the climate crisis; advance environmental justice; and invest in communities. The objective of these infrastructure programs will create an influx of union jobs and expand the economy equitably in subsequent years.

The BIL is a generational investment in our nation, integrating a safer and healthier framework for all communities. The legislation invests $700 million annually from FY 2022 through FY 2026, totaling $3.5 billion, into the IHS Sanitation Facilities' Construction Program to support crucial sanitation projects. The IHS Sanitation Facilities' Construction program provides technical and financial assistance to American Indian tribes and Alaska Native villages to develop robust drinking water sources, reliable sewage systems, and solid waste disposal facilities. Improved sanitation facilities can prevent conditions related to respiratory, skin, soft tissue, and gastroenteric disease, effectively reducing inpatient and outpatient healthcare visits. Based on 2020 data, IHS estimates each dollar invested in water and sewer infrastructure could yield $1.18 in savings by avoiding direct healthcare costs for these diseases.

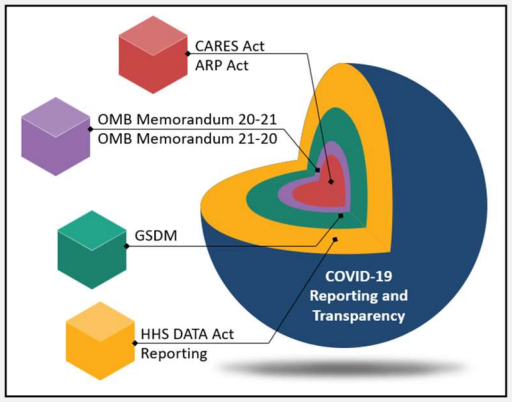
IHS will allocate approximately $653.4 million in FY 2024 to support project construction, of which $613.8 million is FY 2024 BIL funding and $39.6 million is FY 2024 enacted appropriations, including Congressionally Directed Spending projects. When combined, the FY 2024 BIL funding and annual appropriations will enable IHS to fully fund construction costs for 91 projects. These allocations align with recommendations from tribal leaders, prioritizing projects that have progressed through planning phases to seamlessly transition into the design and construction stages.

Digital Accountability and Transparency Act of 2014

The *Digital Accountability and Transparency Act of 2014* (DATA Act) expanded the *Federal Funding Accountability and Transparency Act of 2006* (FFATA) to enhance accountability and transparency in federal spending, making federal expenditure information more accessible to the public. Specifically, the DATA Act directed the federal government to incorporate consistent data standards for developing and publishing reports and make more information, including award-related data, available on USAspending.gov. Among other goals, the DATA Act aimed to improve the quality of USAspending.gov information by simplifying reporting requirements with clear data standards and including agency verification through regular reviews of published financial and award data.

Under existing FFATA requirements, procurement, financial assistance, and recipient award data are collected in government-wide databases. The DATA Act requires agencies, including HHS, to generate data from the entity's accounting systems using common fields, formats, and definitions for financial and award data in accordance with the Government Spending Data Model. Treasury's DATA Act Broker then merges HHS's financial system data with the existing FFATA data using key data elements. In FY 2024, HHS's award-level obligations reported to Treasury represented $1,855.9 billion, an increase of $34.0 billion from the $1,821.9 billion reported in FY 2023. HHS also successfully reconciled an average of 99 percent of financial obligations to award-level obligations for FY 2024.

Quarterly, HHS leadership certifies the accuracy, completeness, and timeliness of this data. Since the first required DATA Act submission in May 2017, HHS has successfully aligned internally maintained data sets and externally managed data sets for valid and reliable submissions to Treasury's DATA Act Broker for publication on USAspending.gov.



Just as FFATA expanded with the DATA Act, evolving federal reporting requirements continue to leverage the success of preceding transparency requirements. The graphic above represents how multiple COVID-19 legislative publications each built upon preceding legislation, drove a holistic reporting and transparent approach, beginning with Section 15011 of the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) at the core. OMB clarified in Memorandum M-20-21, *Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019*, that the DATA Act would be used as the reporting vehicle for COVID-19 spending data and that effort was expounded upon OMB Memorandum M-21-20 to implement the *American Rescue Plan Act of 2021* (ARP). Treasury then revised the Government Spending Data Model reporting standards to provide agencies the methodology to report monthly COVID-19 spending for public transparency.

Federal Information Technology Acquisition Reform Act

The *Federal Information Technology Acquisition Reform Act* (FITARA), was enacted on December 19, 2014. The Act established an enterprise-wide approach to federal IT investments and provided the CIO of CFO Act agencies with greater authority over IT investments, including authoritative oversight of IT budgets, budget execution, and IT-related personnel practices and decisions. FITARA outlines specific requirements related to:

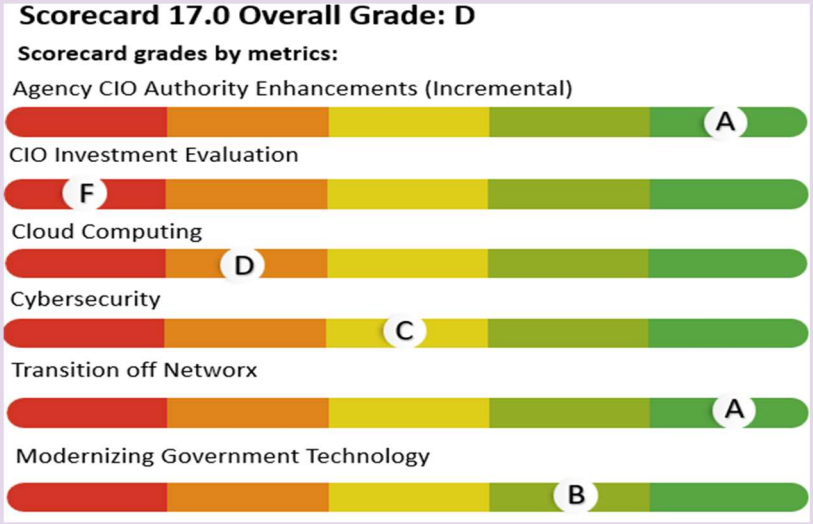
1. Agency CIO Authority Enhancements
2. Enhanced Transparency and Improved Risk Management in IT Investments
3. Portfolio Review
4. Data Center Consolidation Initiative
5. Expansion of Training and Use of IT Cadres
6. Maximizing the Benefit of the Federal Strategic Sourcing Initiative
7. Governmentwide Software Purchasing Program

Over the last year, HHS strengthened its implementation of FITARA by focusing on (1) cost savings derived from IT investments through continued consolidation and closure of data centers; (2) continued implementation of the Enterprise Infrastructure Solutions (EIS) transition; (3) incremental development that is mandatory for Major IT Investments; (4) Cybersecurity; and (5) updated CIO Risk Ratings for Standard and Major IT investments. HHS also continued its efforts related to CIO authorities, delegation of authority, and responsibilities under the law.

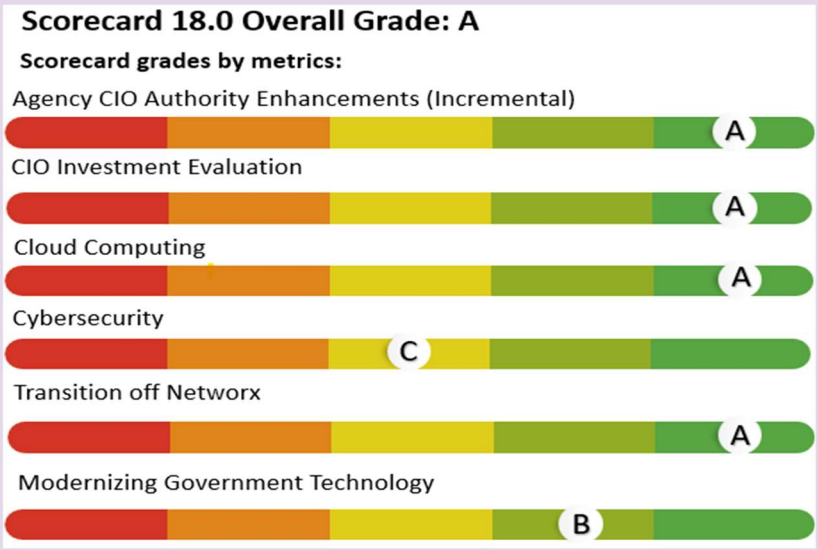
Did You Know?

Under the FITARA, the Government Accountability Office (GAO) prepares a scorecard in collaboration with the US House Oversight and Reform Committee to measure federal agencies' performance in meeting the requirements of the FITARA and other technology priorities. GAO releases agency scorecards twice a year with grades from "A" to "F" on the overall performance. The FITARA scorecard focuses on five metrics: CIO investment evaluation, cloud computing, cybersecurity, transition off Networx, and modernizing government technology.

On the FITARA 17.0 Scorecard, released February 1, 2024, HHS received an overall grade of "D." See metrics grades below:



HHS immediately identified and executed corrective actions when the FITARA 17.0 Scorecard was released. In addition to addressing the two low-scoring metrics, HHS took a holistic approach to proactively identify gaps to ensure compliance with all FITARA requirements and improve scorecard grade. The Department's effective corrective actions and collaborative partnership with OpDivs led to HHS's grade soaring from "D" to "A" on the FITARA 18.0 Scorecard released on September 20, 2024. See metrics grades below:



Federal Managers' Financial Integrity Act of 1982 and Federal Financial Management Improvement Act of 1996

The *Federal Managers' Financial Integrity Act of 1982* (FMFIA) requires federal agencies to assess their internal controls and financial management systems each year. Agency leaders must submit an annual statement confirming whether these controls are working effectively and if their financial systems meet government-wide standards. Section 2 of the FMFIA covers internal control requirements, while Section 4 addresses system compliance. Agencies also need to report any major deficiencies and outline plans to fix them.

In September 2014, GAO released updated internal control standards for the federal government, effective in FY 2016. These standards focus on principles related to operations, reporting, and compliance. In July 2016, the OMB updated Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, which emphasizes integrating internal control processes and ERM to improve accountability in federal programs. The Department works with its OpDivs and StaffDivs to meet these requirements.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems with mandated requirements. FFMIA expanded on FMFIA by requiring agencies to implement and maintain financial management systems that substantially comply with federal financial management system requirements, applicable federal accounting standards, and the U.S. Standard General Ledger at the transaction level. OMB Circular A-123, Appendix D, *Management of Financial Management Systems – Risk and Compliance*, provides guidance on a risk-based approach for assessing compliance with FFMIA.

HHS has strong internal control and risk management programs. The Department works closely with its OpDivs and StaffDivs to remediate major deficiencies and noncompliance issues by identifying the root causes and ensuring active oversight of corrective actions. For more details, see the "Internal Control" and "Management Assurance" sections.

The Patient Protection and Affordable Care Act

The *Patient Protection and Affordable Care Act* (PPACA) established Health Insurance Exchanges through which qualified individuals and qualified employers can purchase health insurance coverage. During the FY 2024 Open Enrollment Period, 21.3 million consumers enrolled nationwide, including five million new consumers.

Many individuals who enroll in Qualified Health Plans through individual federally facilitated Exchanges are eligible to receive a premium tax credit to reduce their health insurance premium costs. Premium tax credits can be paid in advance directly to the consumer's Qualified Health Plan insurer. Consumers then claim the premium tax credit on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service on this process.

The PPACA also includes provisions for addressing healthcare fraud and abuse, strengthening sentences for perpetrators of fraud, enhancing screening procedures, and strengthening provider monitoring. These authorities have facilitated the federal government's efforts to reduce improper payments. For detailed information on improper payment efforts, see the "Other Information" section, under "Payment Integrity Report."

Inflation Reduction Act of 2022

The *Inflation Reduction Act of 2022* strengthened the Medicare program by lowering prescription drug spending for Medicare beneficiaries, redesigning the Part D program, stabilizing prescription drug premiums, capping the cost for a month's supply of covered insulin products at $35, and granting Medicare the power to directly negotiate with drug manufacturers for fair pricing of physician-administered drugs covered under Part B and retail prescription drugs covered under Medicare Part D. The *Inflation Reduction Act of 2022* has also made exchange plans under the PPACA more affordable, which has led to the lowest uninsured rate in history.

In its second year, the law continues to provide free vaccines recommended by the Advisory Committee on Immunization Practices to individuals with Medicare Part D; in 2023, more than 10 million vaccines were administered. Additionally, the *Inflation Reduction Act of 2022* capped out-of-pocket drug costs for some Medicare enrollees at approximately $3,500 in 2024. As of June 30, 2024, nearly 1.5 million individuals benefitted from the cap in the catastrophic coverage phase and had no additional cost-sharing on prescription drugs for the year. Lastly, the *Inflation Reduction Act of 2022* is expanding eligibility for the Extra Help program, which is currently available to Medicare enrollees who earn less than 150 percent of the federal poverty level. The program provides enrollees with $0 premiums, $0 deductibles, and fixed or reduced copays.

The *Inflation Reduction Act of 2022* continues to lower net healthcare premiums for working families by extending enhanced premium tax credits originally enacted under ARP through 2025. This has resulted in millions of people covered under the PPACA continuing to see premium savings of at least $800 per year or qualify for $0 premiums. In addition to the *Inflation Reduction Act of 2022*, the *No Surprises Act* also went into effect in 2022, strengthening the affordability of healthcare and protecting Americans with group and individual health plans from surprise medical bills. Consumers have billing protections when getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers, preventing an estimated one million surprise bills per month.

Payment Integrity Information Act of 2019

Improper payments occur when a payment is made in an incorrect amount under statutory or other legally applicable requirements. If agencies cannot determine if a payment is proper due to missing or insufficient documentation, it is classified as "unknown." Additionally, payments made to the correct recipient in the correct amount may still be considered "technically improper" if they violate any applicable laws or regulations.

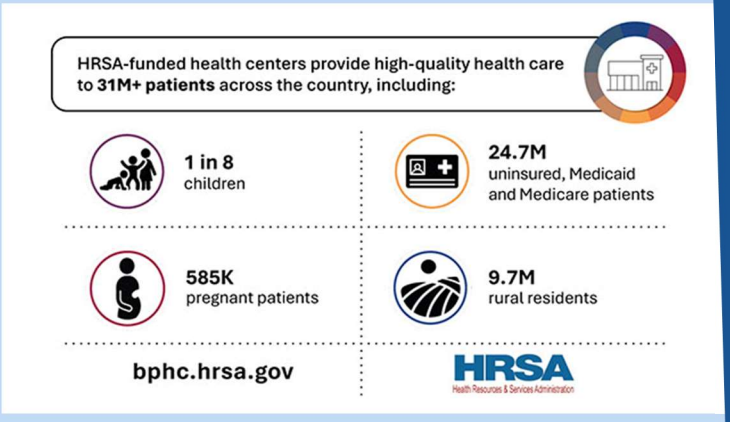
Under the *Payment Integrity Information Act of 2019* (PIIA), agencies are required to assess their programs and activities to identify those that may be susceptible to significant improper payments (known as risk-susceptible programs). These programs must calculate improper payment estimates, establish reduction targets, and develop and implement corrective actions. HHS actively works to prevent, detect, and reduce improper payments by rigorously reviewing its programs and activities using advanced risk models, statistical estimates, and strong internal controls.

HHS continues to demonstrate leadership in ensuring payment integrity by maintaining a robust and longstanding estimation and reporting process. Over the years, HHS has implemented effective corrective actions to prevent, detect, and reduce improper payments across its programs. In accordance with PIIA, HHS conducted 89 improper payment risk assessments in FY 2024, reflecting more than a 50 percent increase from FY 2023. No new risk-susceptible programs were identified.

HHS publishes improper payment estimates and accompanying information for 11 of the 12 risk-susceptible programs in the FY 2024 AFR. In addition, HHS utilizes the Do Not Pay portal to verify both payments and recipients, helping to identify potential improper payments or ineligible recipients. In FY 2024, HHS screened approximately $877 billion in Treasury-disbursed payments through the Do Not Pay portal. For a detailed overview of HHS's initiatives to reduce improper payments and combat fraud, please refer to the "Payment Integrity Report" in the "Other Information" section.

Did You Know?

HRSA released new data showing over 31 million total patients served at HRSA-funded health centers in 2023—an increase of 2.7 million since 2020. HRSA-funded health centers are required to treat all patients regardless of ability to pay, and in 2023 more than 90 percent of health center patients had incomes less than 200 percent of the 2023 Federal Poverty Guidelines. Health centers are now serving one in eight children across the country, more than 9.7 million patients in rural areas, over 6.4 million patients who live in or near public housing, and over 1.4 million people experiencing homelessness.



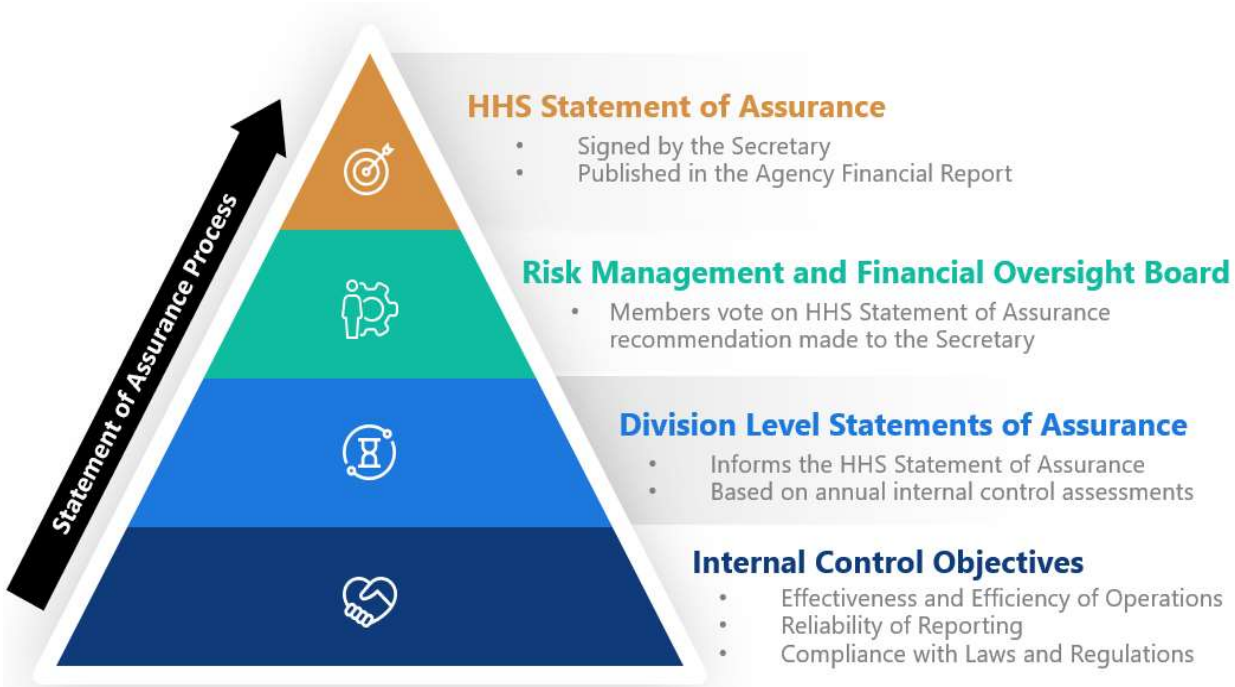
Internal Control

FMFIA requires agency heads to annually assess and report on the internal controls and financial systems that protect federal programs. This ensures that operations are efficient, reporting is accurate, and the agency complies with laws and regulations. Safeguarding assets is part of this process. HHS conducts risk-based evaluations of its internal controls in accordance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. HHS continues to improve ERM activities and the integration of internal controls.

OMB Circular A-123 provides guidance on enhancing accountability and program effectiveness by managing risks and regularly assessing internal controls. HHS aims to strengthen its internal control process to better identify risks, develop effective responses, and take timely corrective actions. Ongoing communication with the OpDivs and StaffDivs helps facilitate the assessment of internal control plans, including those related to disasters, and improves processes to ensure controls meet management's objectives.

HHS management is responsible for maintaining effective internal controls. As part of this responsibility, management regularly assesses internal controls, and executive leadership provides annual assurance statements on their effectiveness. The HHS Risk Management and Financial Oversight Board reviews the assurance statements from the OpDivs and StaffDivs to recommend Department-wide assurance for the Secretary's annual Statement of Assurance, as illustrated in **Figure 21**.

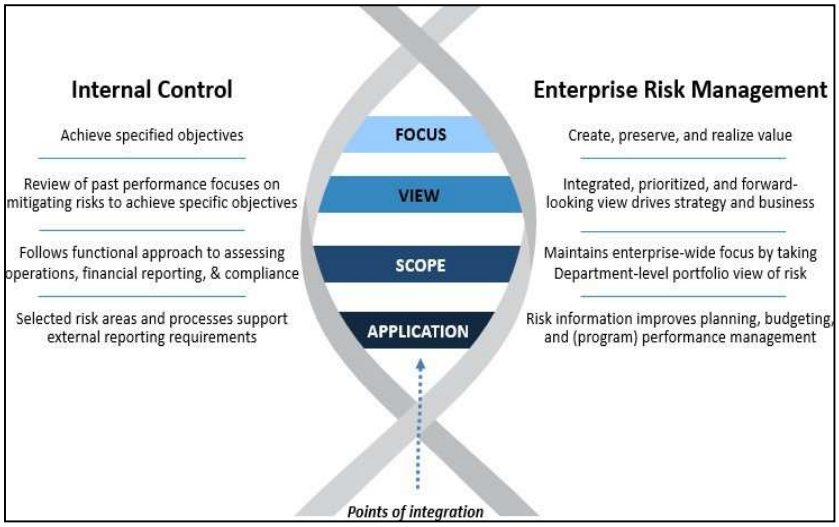
Figure 21: Secretary's Annual Statement of Assurance Process



Enterprise Risk Management

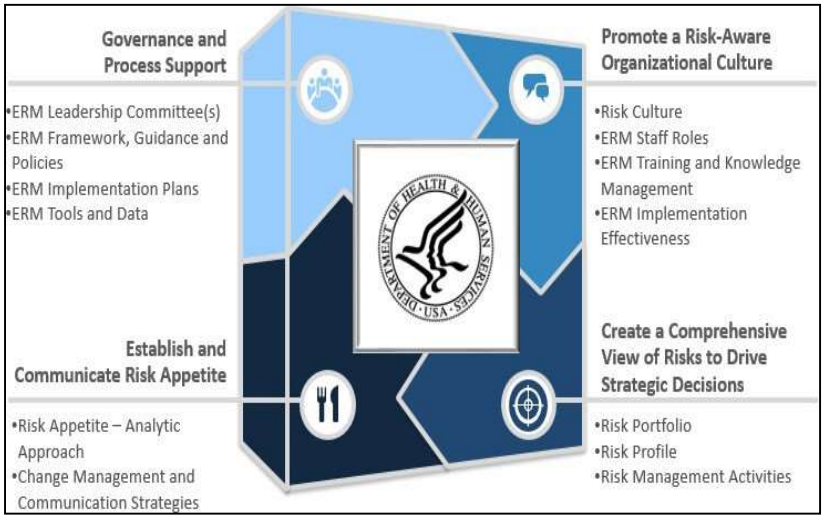
As required by the 2016 update to OMB Circular A-123, federal agencies must implement an ERM capability to ensure Federal managers are effectively managing risks an agency faces toward achieving its strategic objectives and arising from its activities and operations. ERM is a strategic discipline that enables agencies to address the full spectrum of organizational risks and opportunities. As illustrated in **Figure 14**, integrating ERM into Department, OpDiv, and StaffDiv level operations improves HHS's ability to deliver on its mission of enhancing and protecting the health and well-being of all Americans. By incorporating ERM capabilities into daily operations, HHS enhanced its speed and agility in adapting to uncertainties and emerging risks that might otherwise impact its ability to execute the mission, achieve goals, and meet objectives.

Figure 14: ERM and Internal Control are Integrated in HHS's Financial Management DNA



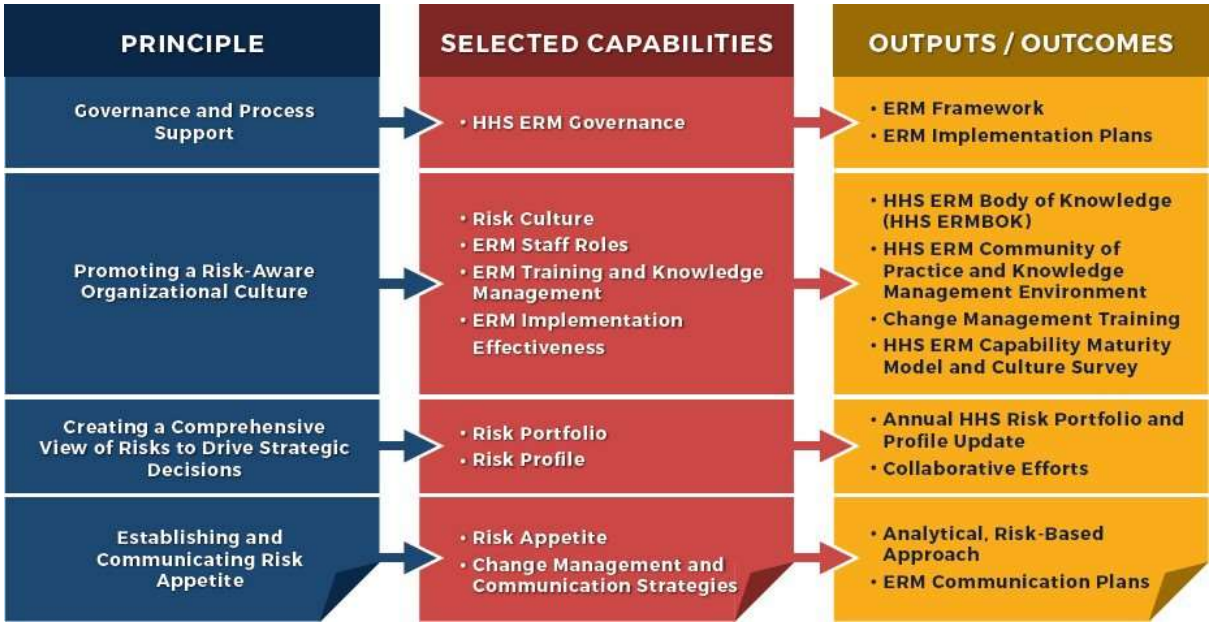
HHS ASFR supports Department-wide ERM implementation through the HHS ERM Council, which consists of senior career executives across HHS's OpDivs and StaffDivs. The ERM Council was originally established in 2010 as the HHS Program Integrity Coordinating Council, to focus on program integrity risk management concerns. The Council expanded its focus in 2014 by adopting ERM to improve risk management efforts throughout the Department and formally updated its charter and name in 2016 to the HHS ERM Council. The HHS ERM Council provides an internal forum for sharing and coordinating Department-wide enterprise risk management efforts. HHS facilitates ERM implementation by: translating the Department-level ERM Framework displayed in **Figure 15** into operational steps; serving as an ERM resource and liaison for OpDivs and StaffDivs; developing and advising on ERM guidance, tools, and techniques that can be tailored by OpDivs and StaffDivs; and providing approaches to support Division-level ERM implementation. Working closely with OpDiv and StaffDiv ERM leads and subject matter experts, HHS supports the implementation of a robust ERM culture and ERM capabilities throughout the Department.

Figure 15: Principles-Based HHS ERM Framework and Capabilities



The HHS ERM Framework, as illustrated in **Figure 16** outlines the principles-based approach and capabilities that HHS uses to implement and mature ERM. By focusing on principles and capabilities rather than an annual risk profile, HHS's ERM Framework offers flexibility for OpDivs and StaffDivs to manage the pace of change. OpDivs and StaffDivs are encouraged to tailor the ERM Framework to align with their diverse operating cultures and missions. This includes tailoring the portfolio of existing and emerging risks and opportunities considered, and applicable governance to oversee risk management activities. HHS ERM Principles-Based Framework translates selected capabilities into outputs and outcomes, as shown in **Figure 16.**

Figure 16: HHS ERM Principles-Based Framework Translates Capabilities into Outputs and Outcome



Management Assurances

Statement of Assurance

U. S. 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 managing risks and maintaining effective internal control to meet the objectives of the *Federal Managers' Financial Integrity Act of 1982* (FMFIA). The FMFIA aims to ensure (1) effective and efficient operations; (2) reliable reporting; and (3) compliance with laws and regulations, including safeguarding assets.

HHS conducted its assessment of risk and internal control in accordance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. Based on the results of the assessment, the Department provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2024, except for material noncompliance with the *Payment Integrity Information Act of 2019*. HHS is taking corrective actions to address the noncompliance as described in the "Summary."

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that substantially comply with federal financial management system requirements, federal accounting standards, and the United States Standard General Ledger at the transaction level. HHS conducted its evaluation of financial management systems compliance in accordance with OMB Circular A-123. Based on the results of this assessment, HHS provides reasonable assurance that its financial management systems substantially comply with the FFMIA and conform to the objectives of FMFIA.

HHS will continue to ensure accountability and transparency in managing taxpayer dollars and will strengthen its internal controls and financial management systems.

/Xavier Becerra/

Xavier Becerra
Secretary
November 14, 2024

Management Assurances

Summary

***Payment Integrity Information Act of 2019* (PIIA)**

HHS identified material noncompliance with PIIA due to statutory limitations (Section 417 of the *Social Security Act*, 42 U.S.C. 617) preventing the Department from reporting an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program. The statutory limitations do not require the states to provide the data needed to develop an estimate. These limitations have been reported in previous years and are still in place. Without data from states, HHS is exploring ways to measure and report an improper payment estimate for the TANF program. In FY 2025 President's Budget request, HHS proposed new legal authority to collect more detailed data on TANF to improve spending oversight and develop an improper payment estimate. The noncompliance with PIIA, along with corrective actions and timelines for resolution, are discussed in more detail in the "Payment Integrity Report" of the "Other Information" section.

Financial Summary and Highlights

For the 26th consecutive year, HHS received an unmodified or "clean" audit opinion on the Consolidated Balance Sheets, Statements of Net Cost, and Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources, and related notes for the year ended September 30, 2024. HHS received a disclaimer on the Statement of Social Insurance (SOSI), Statement of Changes in Social Insurance Amounts (SCSIA), and related notes, due to the uncertainty of the long-range assumptions. HHS takes pride in the preparation of the financial statements, yet it can sometimes be difficult to draw the relationships between the information in the statements and the overall performance of an agency. This section is presented as an interpretation of the principal financial statements, as well as selected notes to the principal financial statements. HHS presents these in Section II, "Financial Section". Included in this analysis is a year-over-year summary of key financial balances, nature of significant changes, and highlights of key financial events to assist readers in establishing the relevance of the financial statements to the operations of HHS.

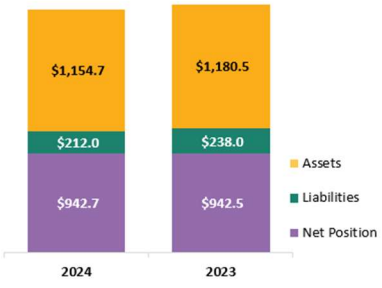
As a federal entity, HHS's financial position and activities are significant to the government-wide statements. Based on the *FY 2023 Financial Report of the United States Government*, HHS's net operating cost was the largest across the entire federal government.[1] A similar relationship exists within HHS, where the Department is significantly represented by one OpDiv, CMS. CMS alone consistently stewards the largest share of HHS's resources. Therefore, noteworthy changes in HHS balances are primarily related to fluctuations in CMS program activity.

Balance Sheets

To communicate performance for HHS at fiscal year (FY)-end, the Consolidated Balance Sheets show the resources available to HHS (Assets) and claims against those assets (Liabilities). The remainder represents the equity retained by HHS (Net Position). The table below summarizes the major components of the FY 2024 and FY 2023 year-end balances of HHS's assets available for use, the liabilities owed by HHS, and the equity retained by HHS.

Financial Conditions Summary
(In Billions)

	2024	2023	$ Change (2024-2023)	% Change (2024-2023)
Fund Balance with Treasury	$ 676.9	$ 695.6	$ (18.7)	(3)%
Investments, Net	406.6	360.4	46.2	13%
Accounts Receivable, Net	39.3	40.0	(0.7)	(2)%
Advances and Prepayments	2.9	47.7	(44.8)	(94)%
Other Assets	29.0	36.8	(7.8)	(21)%
Total Assets	**$ 1,154.7**	**$ 1,180.5**	**$ (25.8)**	**(2)%**
Entitlement Benefits Due and Payable	141.6	159.5	(17.9)	(11)%
Pensions and Other Post-Employment Benefits	21.1	19.4	1.7	9%
Advances from Others and Deferred Revenue	4.6	3.6	1.0	28%
Accrued Liabilities	17.2	17.4	(0.2)	(1)%
Contingencies & Commitments	15.0	27.5	(12.5)	(45)%
Other Liabilities	12.5	10.6	1.9	18%
Total Liabilities	**$ 212.0**	**$ 238.0**	**$ (26.0)**	**(11)%**
Net Position	**$ 942.7**	**$ 942.5**	**$ 0.2**	**0%**
Total Liabilities and Net Position	**$ 1,154.7**	**$ 1,180.5**	**$ (25.8)**	**(2)%**



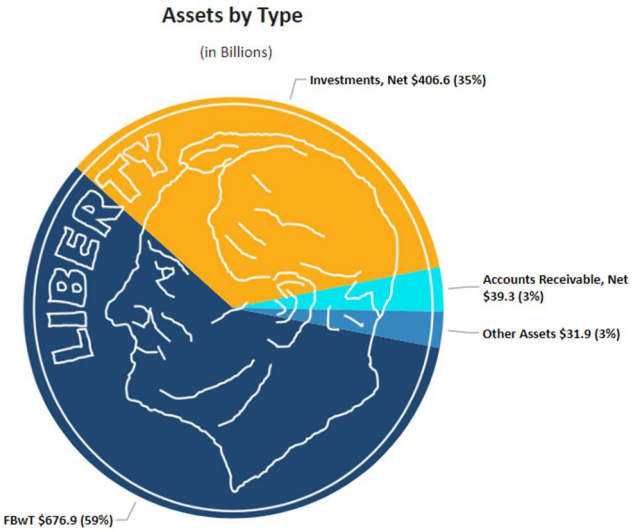
[1] HHS's net cost is 22 percent of the federal government's total costs, Department of Veterans Affairs' net cost is 18 percent, Social Security Administration's net cost is 18 percent, and Department of Defense's net cost is 13 percent. All remaining agencies combined only represent 29 percent. Source: *FY 2023 Financial Report of the U.S. Government*.

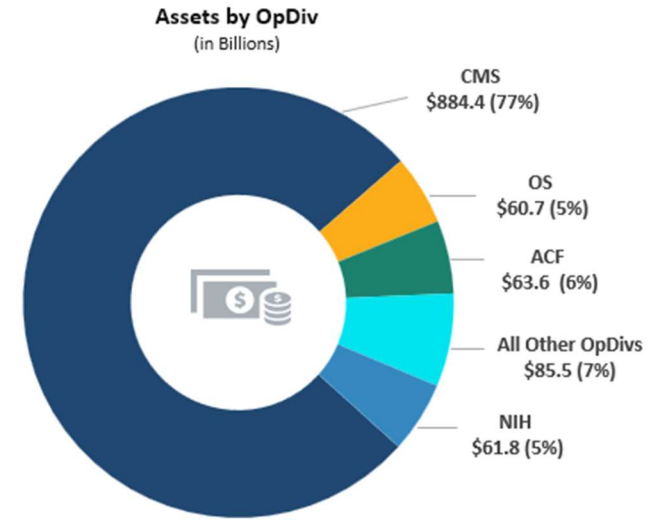
Assets

The total assets for HHS were $1,154.7 billion at year-end, representing the value of what HHS owns and manages. This is a decrease of approximately $25.8 billion or 2 percent under September 30, 2023. Fund Balance with Treasury (FBwT) and Investments comprise $1,083.5 billion or 94 percent of HHS's total assets. FBwT, Investments, Advance and Prepayments, and Other Assets collectively decreased $25.1 billion or 2 percent.

Advances and Prepayments had a decrease of $44.8 billion or 94 percent under FY 2023, which is primarily due to the Prescription Drug and Medicare Advantage benefit payments for October 1, 2023, that occurred on September 29 instead of October 1. FBwT had a decrease of $18.7 billion or 3 percent under FY 2023, which is primarily due to decreases in the Public Health and Social Services Emergency Fund and *Defense Production Act* from lower carryover balances and no further funding for this program. In addition, Other Assets had a decrease of $7.8 billion or 21 percent under FY 2023, which is primarily attributed to the decrease in Inventory and Related Property due to less vaccines and therapeutics. These decreases are offset by Investments increase of $46.2 billion or 13 percent over 2023, which is due to higher tax collections and the Managed Care payments for October 1, 2023, that occurred on September 29 instead of October 1, reducing the 2023 investment balance.

The HHS "Assets by OpDiv" chart shows asset distribution within HHS, excluding eliminations. The OpDiv asset balances ranged from $359 million for AHRQ (shown in All Other OpDivs) to $884.4 billion for CMS. OS had the largest change, a decrease of $22.6 billion or 27 percent primarily due to decrease in FBwT as mentioned above.

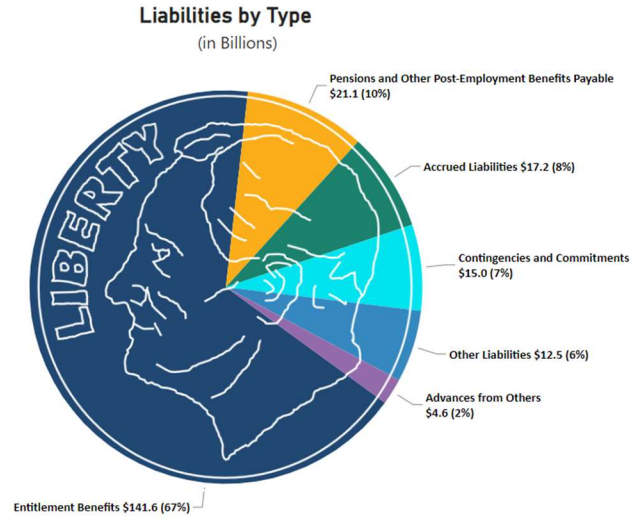




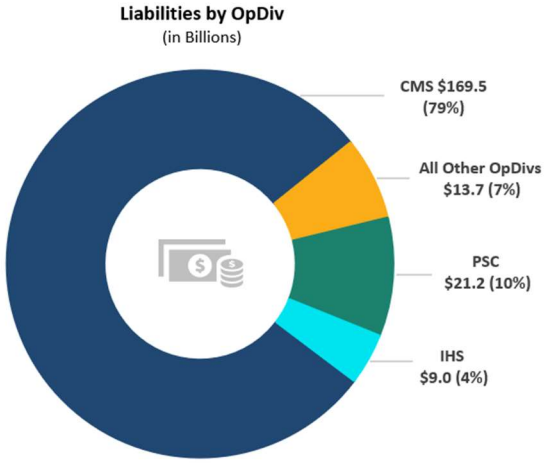
Liabilities

The total liabilities for HHS were $212.0 billion at year-end, representing the amounts HHS owes from past transactions or events. Liabilities had a decrease of approximately $26.0 billion or 11 percent under September 30, 2023.

This is mainly attributed to decreases in Entitlement Benefits Due and Payable and Contingencies and Commitments. Entitlement Benefits had a decrease of $17.9 billion or 11 percent under FY 2023, which is due to a decrease in medical services and claims incurred but not reported (IBNR). Contingencies and Commitments had a decrease of $12.5 billion or 45 percent under FY 2023, which is due to HI for legal contingent liabilities recorded in FY 2023 that were not recorded in September 2024, as well as a decrease in the Medicaid State Plan Amendment accrual.



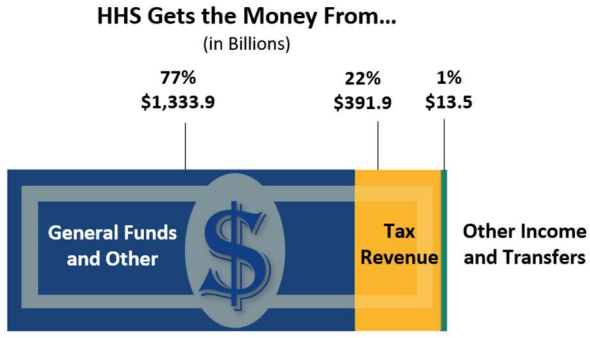
Financial Summary and Highlights



The HHS "Liabilities by OpDiv" chart shows liability distribution within HHS, excluding eliminations. The OpDivs with the largest and smallest asset balances are also the OpDivs with the largest and smallest liabilities. With the majority share, CMS reports $169.5 billion or 79 percent of the HHS liabilities, while AHRQ (shown in All Other OpDivs) has liabilities of $17 million. CMS had the largest OpDiv dollar value decrease in liabilities under FY 2023 of $30.0 billion due to decreases in Entitlement Benefits Due and Payable and Contingencies and Commitments, as mentioned previously.

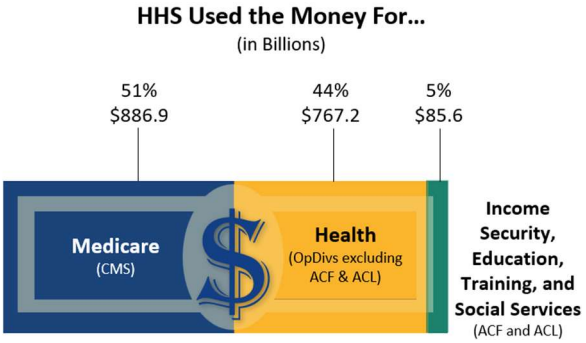
Statement of Changes in Net Position

The Statement of Changes in Net Position displays the activities affecting the difference between the beginning net position and ending net position, as shown on the HHS Consolidated Balance Sheets. This is also represented as the difference between assets and liabilities. Changes in assets are shown by identifying where HHS gets the money from, known as financing sources.



HHS receives the majority of the funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. HHS's largest financing source, General Funds and Other, decreased $45.3 billion or 3 percent under FY 2023 and is primarily due to decrease related to the increase in return of Medicare Supplementary Medical Insurance (SMI) indefinite and canceled year authority, offset by increase in Medicaid appropriations. The fluctuation in tax revenue of $29.4 billion or 8 percent is related to higher *Federal Insurance Contribution Act* tax revenue due to the rise in wages and low unemployment rate.

Statements of Net Cost



The Consolidated Statements of Net Cost represents how HHS spent the money. This can also be stated as the difference between the costs incurred by HHS's programs less associated revenues. The Net Cost of Operations for the year ended September 30, 2024, totaled approximately $1,739.3 billion. The "HHS Used the Money For" chart shows consolidating costs by major budget function[2], which are the categories displayed in the Federal Budget. Most agencies have one or two budget functions, where HHS has many. HHS classifies costs by major budget functions such as Medicare, Health, Income Security, and Education, Training, and Social Services. This is shown on the Consolidating Statement of Net Cost by Budget Function in Section III, "Other Information". In FY 2024, total net costs for Medicare of $886.9 billion and Health of $767.2 billion account for 95 percent of HHS's annual net costs.

[2]Totals in the chart are exclusive of intra-HHS eliminations from the Consolidating Statement of Net Cost by Budget Function. This statement can be found in Section III, "Other Information".

Financial Summary and Highlights

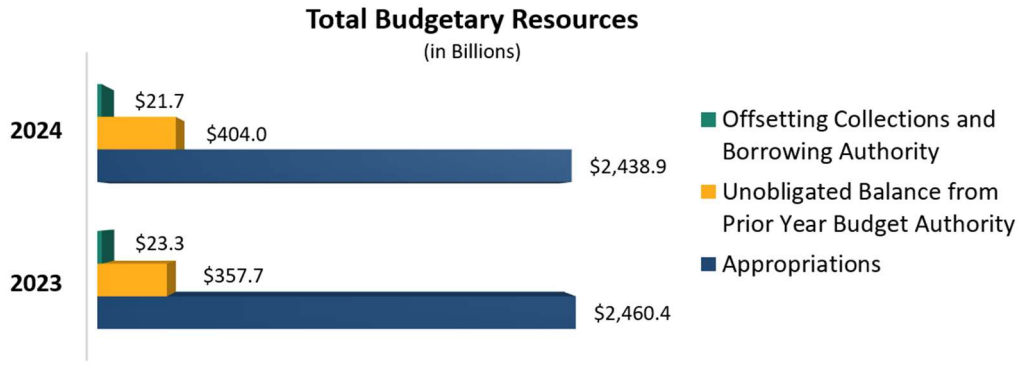
The table below presents FY 2024 Consolidated Net Cost of Operations, which breaks costs into Responsibility Segments between CMS and the remaining OpDivs in Other Segments. Net cost for CMS increased by $21.4 billion or 1 percent over FY 2023, which included increases in Medicare SMI and Hospital Insurance (HI). SMI Part B increased due to an increase of benefit expenses of $42.5 billion and a decrease of $2.2 billion in offsetting receipts. SMI Part D expenses increased by $16.5 billion primarily due to increase in benefit and IBNR expenses and decrease in receivables. SMI revenue increased by $6.7 billion due to increased premiums for the Aged. Medicare HI decreased primarily due to reduction in IBNR expenses of $20.6 billion and the reduction of the 2023 contingency resulted in net decrease in expenses of $19.8 billion, and HI benefit expense increase of $12.5 billion.

Net Cost of Operations
(in Billions)

	2024	2023	$ Change (2024-2023)	% Change (2024-2023)
Responsibility Segments:				
CMS Gross Cost	$ 1,684.5	$ 1,654.1	$ 30.4	2%
CMS Earned Revenue	(163.9)	(154.9)	(9.0)	6%
CMS Net Cost of Operations	$ 1,520.6	$ 1,499.2	$ 21.4	1%
Other Segments:				
Other Segments Gross Cost	$ 225.6	$ 222.7	$ 2.9	1%
Other Segments Earned Revenue	(6.9)	(7.0)	0.1	(1)%
Other Segments Net Cost of Operations	$ 218.7	$ 215.7	$ 3.0	1%
Net Cost of Operations	**$ 1,739.3**	**$ 1,714.9**	**$ 24.4**	**1%**

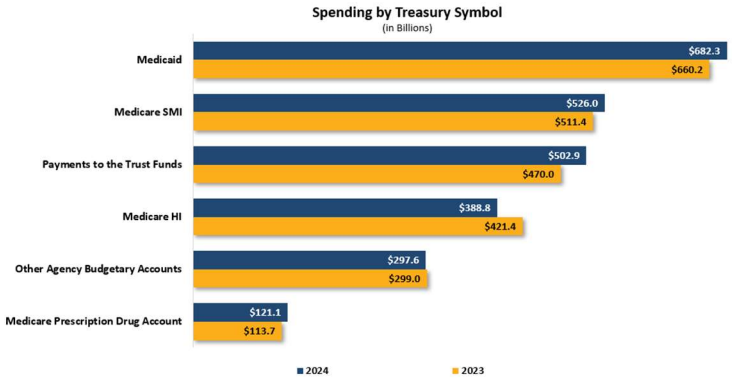
Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout FY 2024 and FY 2023, and the status of those resources at the FY-end. The primary components of HHS's resources, totaling approximately $2.9 trillion for FY 2024, are appropriations from Congress, resources not yet used from previous years (unobligated balances from prior year budget authority), and spending authority from offsetting collections and borrowing authority. FY 2024 Budgetary Resources has remained consistent with FY 2023. The following graph highlights trends in these balances over the past two FYs.



Schedule of Spending

HHS has elected to present the trends in spending in the audited notes to the principal financial statements titled, Combined Schedule of Spending. The chart illustrates spending as of September 30, 2024 and 2023 for the top five Treasury Account Symbols (TAS). The remaining TAS are presented in Other Agency Budgetary Accounts.



The New Obligations and Upward Adjustments line on the Combined Statement of Budgetary Resources is the same as Total Amounts Agreed to be Spent line on the Combined Schedule of Spending. Total obligations for FY 2024 were approximately $43.1 trillion or 2 percent increase over FY 2023.

The HHS's total spending is once again significantly represented by five of CMS's TAS (Medicaid, Medicare SMI, Payments to the Healthcare Trust Funds, Medicare HI, and Medicare Prescription Drug Account) at 88 percent of HHS total obligations. As the American public will see more clearly on the USAspending.gov website, the majority of HHS spending was made through Grants, Subsidies, and Contributions at $1.3 trillion or 50 percent. HHS is the largest grant-making agency in the federal government. Additionally, HHS has incurred obligations for Insurance Claims and Indemnities totaling $1.0 trillion or 41 percent. HHS classifies obligations by items or services provided into categories known as object classes. For more information refer to Note 23, Combined Schedule of Spending in Section II, "Financial Section".

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 for current and future program participants. This projection is considered important information in evaluating the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, Statements of Net Cost, Statements of Changes in Net Position, or Combined Statements of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. With two exceptions, the projections are based on the current-law provisions[3] of the *Social Security Act*. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted.

The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a

[3]Due to the timing and the limited effect on the financial outlook of the trust funds, the projections do not reflect the impact of the Medicare provisions in the *Consolidated Appropriations Act, 2024* (Public Law 118-42), which was enacted on March 9, 2024. The provisions included were temporary extensions of prior policies, the elimination of the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through November of 2032. The estimated impact is less than 0.05 percent of Medicare benefits over FYs 2024 through 2033, and there is no impact beyond 2033.

January 1, 2022, effective date; however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the *Inflation Reduction Act of 2022*. This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the *Inflation Reduction Act of 2022* is to reduce government expenditures for Part B, to increase expenditures for Part D from 2027 through 2030, and to decrease Part D expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10-year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the *Inflation Reduction Act of 2022* will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the *Inflation Reduction Act of 2022*, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the *Inflation Reduction Act of 2022* are likely to result in price growth that is lower than overall health prices and closer to the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative provisions were enacted during the public health emergency that increased spending, and the use of telehealth was greatly expanded. More than offsetting these additional costs during the pandemic, spending for non-COVID care declined significantly.

Now that the public health emergency has ended and Medicare fee-for-service per capita spending has stabilized, the Trustees place a greater reliance on recent experience when developing the cost projections. However, they continue to make three pandemic-related adjustments to the projections. The first is to account for the morbidity improvement in the surviving population, which is expected to continue to affect spending levels through 2029. The second adjustment accounts for the ending of the waiver regarding the 3-day inpatient stay requirement to receive SNF services. The per capita spending projections typically include factors for price updates and changes in the utilization and mix of services. As a result of the expiration of this waiver, the Trustees have increased their inpatient spending growth factor by 1.9 percentage points and decreased the SNF spending growth factor by 7.5 percentage points in 2024. Finally, the third adjustment is to account for home health spending that was still, in 2023, significantly lower than estimated prior to the pandemic. As a result of the recent home health staffing shortages, the Trustees continue to consider the spending level for this service to be suppressed. Thus, they have increased their home health spending growth factor by 2.9 percentage points in each of the next 3 years (2024-2026).

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 $(4.6) trillion, determined as of January 1, 2023, to $(2.6) trillion, determined as of January 1, 2024.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2024, the future cash flow for all current and future participants is $(2.2) trillion for the 75-year valuation period. The comparable cash flow for the closed group of participants, including the combined HI and SMI trust fund assets, is $(12.6) 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; thus, the HI trust fund assets have been declining. The following table shows the 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 declines from 50 percent at the beginning of FY 2020 to 39 percent at the beginning of FY 2022, after which it rises in 2023 and 2024. The ratio is estimated to increase in 2024 as a result of (i) a policy change to exclude medical education expenses associated with MA enrollees from the fee-for-service per capita costs used in the development of MA spending, as described in Section IV.C of the Trustees Report, and (ii) lower spending for inpatient hospital and home health agency services due to a greater reliance on recent experience, as described in Section I of the Trustees Report.

Trust Fund Ratio Beginning of Fiscal Year[4]					
	2020	**2021**	**2022**	**2023**	**2024**
HI	50%	40%	39%	45%	48%

[4]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 (CY) are at least as large as program obligations for the year. Under the intermediate assumptions of the 2024 Trustees Report, the HI trust fund ratio is estimated to increase in 2024 through 2027 before decreasing for the rest of the projection period until the fund is depleted in CY 2036. The assets were $208.8 billion at the beginning of 2024, representing about 50 percent of expenditures projected for 2024, which is below the Trustees' minimum recommended level of 100 percent. The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003.

Long-Term Financing

The short-range financial outlook for the HI trust fund is more favorable than what was projected last year. After 2027, the trust fund ratio declines until the fund is depleted in 2036, five years later than projected in 2023. HI financing is not projected to be sustainable over the long-term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 89 percent in 2036 to 87 percent in 2048, and then to increase to about 100 percent by the end of the projection period.

The primary reason for the projected long-term inadequacy of financing under current law relates to the fact that the ratio of the number of workers paying taxes relative to the number of individuals eligible for benefits drops from 2.8 in 2023 to about 2.1 by 2098. In addition, healthcare costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $2.4 trillion, which is 0.3 percent of taxable payroll and 0.1 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.

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, and their program benefits are quite different in nature.

While differences between the two accounts exist, the SMI trust fund is expected to be adequately financed over the next 10 years and beyond because income from premiums and government contributions for Parts B and D – which are contributions of the Federal Government that the law authorizes to be appropriated and transferred from the general fund of the Treasury – are reset each year to cover projected program costs and ensure a reserve for Part B to provide a contingency for unexpected program variation.

Unlike the Part B account, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect this policy. Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement, the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers, as well as interest payments to the Medicare trust funds and

asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(50.2) trillion.

Even though from a program perspective the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2023, SMI incurred expenditures were 2.3 percent of GDP. By 2098, SMI expenditures are projected to grow to 4.3 percent of the GDP.

Financial Challenges

These Medicare projections continue to demonstrate the need for timely and effective action to address the remaining financial challenges–including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in expenditures. The Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI in the short and long term and to reduce the rate of growth in Medicare costs through viable means. The Trustees recommend that Congress and the executive branch work closely together to expeditiously address these challenges. The sooner solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations–including healthcare providers, beneficiaries, and taxpayers–to adjust their expectations and behavior.

The following table presents key amounts from CMS's basic financial statements for FY 2022 through 2024.

Table of Key Measures[5]
(in Billions)

	2024	2023	2022
Net Position (end of fiscal year)			
Assets	$ 884.4	$ 873.7	$ 765.4
Less Total Liabilities	169.5	199.5	171.9
Net Position (assets net of liabilities)	**$ 714.9**	**$ 674.2**	**$ 593.5**
Costs (end of fiscal year)			
Net Costs	$ 1,521.1	$ 1,499.6	$ 1,383.6
Total Financing Sources	1,548.8	1,477.6	1,430.4
Net Change in Cumulative Results of Operations	**$ 27.7**	**$ (22.0)**	**$ 46.8**
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$ (2,618)	$ (4,630)	$ (5,094)
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	$ (4,630)	$ (5,094)	$ (5,057)
Change in Present Value	**$ 2,012**	**$ 464**	**$ (37)**

[5]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, CMS presents the closed group measure and open group measure. Totals do not necessarily equal the sums of rounded components.

Statement of Changes in Social Insurance Amounts

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. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2024, decreased by $144 billion as a result of advancing the valuation date by 1 year and including the additional year 2098 and by $698 billion because of changes in demographic assumptions. However, changes in the projection base and economic and healthcare assumptions increased the present value by $747 billion and $2,106 billion, respectively. The net overall impact of these changes is an increase in the present value of $2,011 billion.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) 17, *Accounting for Social Insurance* (as amended by SFFAS 37*, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), HHS 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 individuals with Medicare (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 37 does not eliminate or otherwise affect the SFFAS 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 *2024 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 HHS's financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515(b). Although the statements have been prepared from HHS's books and records in accordance with generally accepted accounting principles for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

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.

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SECTION 2:

FINANCIAL SECTION

- Message from the Office of the Assistant Secretary for Financial Resources
- Report of the Independent Auditors
- Department's Response to the Report of the Independent Auditors
- Principal Financial Statements
- Notes to the Principal Financial Statements
- Required Supplementary Information

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Message from the Office of the Assistant Secretary for Financial Resources

I am honored to join Secretary Becerra in presenting the Department of Health and Human Services' (HHS) Fiscal Year (FY) 2024 Agency Financial Report (AFR). This report reflects the Department's commitment to accountability and effective management of one of the world's largest budgets. For the 11th year in a row, HHS has been recognized for outstanding performance in all areas of accountability and transparency. I am confident this year's AFR upholds that same high standard.

In FY 2024, we continued to advance our strategic initiatives focused on workforce, governance, and technology, aligned with the Department's and HHS CFO Community's strategic plans. HHS continues to sustain strong financial stewardship of taxpayer dollars by fostering prudent use of those resources. Among other accomplishments, HHS:

- Saved nearly $500 million through a Contract Cost Reduction Initiative that supported key HHS priorities.
- Continued to monitor COVID funds HHS received across six emergency supplemental appropriations and execute recissions as directed by the *Fiscal Responsibility Act* and *Consolidated Appropriations Act of 2024*, obligating 99 percent, or $467 billion.
- Streamlined and simplified 75+ HHS Notice of Funding Opportunities for grantees, reducing applicant burden and enhancing accessibility of HHS financial assistance awards.
- Made significant progress in improving payment integrity, with no new programs identified as high-risk and a reduction of more than $15 billion in estimated improper payments in existing high-risk programs from FY 2023 to FY 2024.

Approximately $2.9 trillion in budgetary resources flowed through the HHS financial systems portfolio during FY 2024. Despite evolving technological risks, we are proud of the steady improvements in our financial systems' controls and the efficiencies gained through new tools, services, and platforms, such as Robotics Process Automation, Artificial Intelligence, and Oracle Cloud Infrastructure. Our modernization efforts continue to enhance the security, reliability, and availability of HHS financial management systems, allowing us to deliver greater value to our stakeholders.

For the 26th year in a row, HHS received an unmodified, or "clean," opinion on our consolidated balance sheets, related consolidated statements of net costs and changes in net position, and combined statement of budgetary resources. However, the auditors did not issue opinions on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. Strong internal controls, combined with robust management processes for identifying and resolving control issues, has resulted in no auditor-reported material weaknesses since 2018.

HHS continues to enhance its financial management capabilities, safeguarding the resources entrusted to us with integrity and diligence. I sincerely thank our workforce and our partners for their exceptional efforts and collaboration throughout the fiscal year. HHS leadership remains steadfast in building a diverse, committed workforce that prioritizes transparency, accountability, and trust with both internal and external stakeholders. The accomplishments detailed in this report exemplify our unwavering dedication to HHS' mission and service to the American public.

/Lisa Molyneux/

Lisa Molyneux
Principal Deputy Assistant Secretary for Financial Resources, performing the delegable duties of the Assistant Secretary for Financial Resources
November 14, 2024

Report of the Independent Auditors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 14, 2024

TO: The Secretary

FROM: /Amy J. Frontz/
Deputy Inspector General for Audit Services

SUBJECT: *Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2024*, A-17-24-00001

This memo transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2024 financial statements, internal control over financial reporting, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young LLP, to audit the HHS: (1) consolidated balance sheets as of September 30, 2024 and 2023, and the related consolidated statements of net cost and changes in net position; (2) combined statements of budgetary resources for the years then ended; and (3) sustainability statements that comprise the statement of social insurance as of January 1, 2024, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 24-02, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2024 HHS consolidated balance sheets and the related consolidated statements of net cost and changes in net position, and combined statements of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. Ernst & Young was unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2024, 2023, 2022, 2021, and 2020, and the related statements of changes in social insurance amounts for the periods ended January 1, 2024 and 2023. As a result, Ernst & Young was not able to, and did not, express an opinion on the sustainability statements for the specified periods.

Ernst & Young also noted three matters involving internal control over financial reporting. Under the standards established by the American Institute of Certified Public Accountants and the standards applicable to financial audits contained in *Government Auditing Standards*, Ernst & Young did not identify any deficiencies in internal control that it considered a material weakness. Ernst & Young identified significant deficiencies related to HHS's (1) Financial Reporting Systems, Analysis, and Oversight; (2) Program Support Center; and (3) Financial Information Systems. Specifically:

- *Financial Reporting Systems, Analysis, and Oversight*—During the FY 2024 audit, Ernst & Young identified a series of deficiencies in financial systems and processes for producing financial statements. For example:
    - Ernst & Young continued to describe concerns about the number and dollar amount of non-standard HHS journal entries. A significant number of these vouchers are needed to record entries that cannot be recorded through routine processing in HHS Financial Systems. These entries are needed to ensure accurate account balances. Ernst & Young noted that their volume and dollar values comprise a significant portion of HHS's overall financial activity.
    - Consistent with prior year findings, Ernst & Young identified concerns related to accounting and reporting of procurement activities and noted that the National Institutes of Health (NIH) maintains two separate acquisition systems. One of the systems supports 26 of NIH's 27 Institutes and Centers, is fully integrated with the NIH Business System, and provides stringent controls across acquisition and financial management. The other is a standalone system within one Institute that is not integrated with the NIH Business System, requiring alternative methods and tools to transfer acquisitions data to the NIH Business System.[1] Ernst & Young noted that using two systems poses significant financial management risks and additional costs that would not exist if all NIH Institutes and Centers operated within one system.
    - Ernst & Young noted that HHS continued to identify challenges that prevented HHS from meeting certain monitoring requirements of its programs for improper payments. According to HHS, an improper payment estimate for 1 of its 12 risk susceptible programs could not be achieved. In addition, HHS indicated to Ernst & Young that, in FY 2024, HHS had limited resources to execute a full rotation of required risk assessments of programs with outlays exceeding $10 million but

[1] Specifically, the Contract Award Management System is a standalone system within the National Heart, Lung, and Blood Institute. Ernst & Young noted that there appears to be no functional, operational, or cost benefits to maintaining an acquisition system that supports only one NIH Institute.

would expand its assessment process to cover these programs by the end of 2025.[2] For the Centers for Medicare & Medicaid Services (CMS), Ernst & Young noted that there is an increased risk that improper payment rates for Medicaid and the Children's Health Insurance Program (CHIP) could exceed the statutory 10-percent threshold when flexibilities afforded by the COVID-19 public health emergency expire. The Foster Care Program, administered by the Administration of Children and Families (ACF), reported an improper payment rate for the first year since FY 2020, but the measurement was only based on six states. Another program administered by ACF, Headstart, reported a significant increase in the improper payment rate form 5.1 percent of FY 2023 to 11.98 percent in FY 2024.

- During FY 2024, Ernst & Young noted that the Administration for Strategic Preparedness and Response (ASPR) completed a risk assessment and updated cycle narratives for its Budget Execution and Monitoring, Inventory Management, Grants Management, and Purchase Card cycles, but did not perform testing to assess the effectiveness of its internal control systems. Its review was limited to the development of corrective action plans for findings regarding Inventory that resulted from the FY 2023 financial statement audit, and HHS management was unaware that ASPR had not tested the effectiveness of internal controls over financial reporting, as required by OMB Circular A-123. Further, Ernst & Young noted deficiencies on grant- and contract-related activities dating back more than 12 years, with some having been identified consistently over multiple years and at more than one operating division.

- Consistent with prior year findings, Ernst & Young concluded that the aggregation of deficiencies identified at CMS to be a significant deficiency for CMS's internal control over final reporting. Ernst & Young identified a number of areas (e.g., Medicare entitlement benefits due and payable) in the FY 2024 audit that merit continued focus.

- *Program Support Center*–Ernst & Young noted that, beginning in FY 2023, the Program Support Center (PSC) experienced significant turnover at all levels of the organization, leaving many positions unfilled for months. It also noted that, at the onset of FY 2024, PSC did not complete appropriate transitions because succession plans were insufficient. Ernst & Young identified certain PSC internal controls that were not executed timely, or were insufficiently monitored to identify errors, omissions, and incorrect information. Late in the FY 2024 closing process, the HHS Assistant Secretary for Financial Resources (ASFR) Office of Finance also identified discrepancies in multiple accounts when they were preparing the HHS Agency Financial Report. ASFR's follow-up identified several entries PSC had not properly recorded during its close period. PSC indicated to ASFR that it knew about the mistakes, but the team was impacted by limited resources and the high staff turnover noted.

[2] The Payment Integrity Information Act of 2019 (P.L. No. 116-117) requires each agency to perform a risk assessment not less frequently than once every 3 FYs for each program and activity that exceeds $10 million of all reported program or activity payments made during that fiscal year.

- *Financial Information Systems*—Ernst & Young noted that many HHS financial systems, including CMS's systems, have migrated their platform and infrastructure needs to cloud-based providers. HHS is in the process of updating its business and information technology security processes to address the new infrastructure. However, Ernst & Young noted that many historical challenges have remained challenges in the cloud-based environment. For example, Ernst & Young identified deficiencies related to controls over system access and information security (e.g., access control and segregation of duties) that could affect HHS's financial reporting. Ernst & Young also noted that it continues to identify deficiencies in implementing and monitoring controls, including controls over privileged access to CMS's information systems.[3] These deficiencies for both HHS and CMS collectively constitute a significant deficiency in internal control.

Ernst & Young identified several instances related to HHS's noncompliance with laws and other matters. For example, during FY 2024, HHS was not in full compliance with the Payment Integrity Information Act of 2019 (PIIA, P.L. No. 116-117). HHS has developed and reported improper payment rates for 11 of its 12 risk-susceptible programs. However, for the remaining program—the Temporary Assistance for Needy Families—HHS is working to address various challenges to enable it to develop and report an improper payment estimate. Additionally, although HHS has calculated and reported an improper payment estimate for the federally-facilitated Exchange of the APTC program, it has not calculated and reported an improper payment estimate for the State-based Exchanges, which have been deemed susceptible to significant improper payments. As indicated above, HHS reported the Foster Care Program had not yet completed a full rotation of all states. Also, as indicated above, HHS reported an improper payment rate of 11.98 percent for the Headstart program, exceeding the statutorily required maximum of 10 percent. Further, Ernst & Young noted that CMS did not comply with PIIA, as its recovery activities were delayed for the identified improper payments of the Part C program. We will report further on agency compliance with improper payment reporting, as required by the PIIA, later in FY 2025.

Finally, Ernst & Young reported that HHS management determined that HHS may have potential violations of the Antideficiency Act (31 U.S.C. chapters 13 and 15) related to an obligation of funds for conference spending at the Food and Drug Administration, certain contract obligations at CMS that occurred in FYs 2014 and 2015, as well as obligations at PSC that occurred between FYs 2006 and 2011. As discussed above, HHS also identified potential violations with laws and regulations related to its acquisition processes. In FY 2020, CMS management was notified that it may have potential violations of the Federal Acquisition Regulation related to contracting matters.

[3] For example, logical access control procedures related to the timely removal of access for terminated personnel supporting CMS were not always followed.

Evaluation and Monitoring of Audit Performance

We reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation, including that related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS *FY 2024 Agency Financial Report*.

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996, or HHS's compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carla J. Lewis, Assistant Inspector General for Audit Services, at (202) 834-5992 or Carla.Lewis@oig.hhs.gov. Please refer to report number A-17-24-00001.

Attachment

cc:
Lisa Molyneux
Principal Deputy Assistant Secretary for Financial Resources, performing the delegable duties of the Assistant Secretary for Financial Resources

Teresa Miranda
Deputy Assistant Secretary
and Deputy Chief Financial Officer

Ernst & Young LLP
Suite 310
1201 Wills Street
Baltimore, MD 21231

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

Report of Independent Auditors

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

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of the U.S. Department of Health and Human Services (HHS), which comprise the consolidated balance sheets as of September 30, 2024 and 2023, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of HHS at September 30, 2024 and 2023, and the results of its net cost of operations, its changes in net position, and its budgetary resources for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts

We were also engaged to audit the sustainability financial statements of HHS, which comprise the statement of social insurance as of January 1, 2024, 2023, 2022, 2021, and 2020, and the related statement of changes in social insurance amounts for the periods ended January 1, 2024 and 2023, and the related notes (collectively referred to as the "sustainability financial statements").

We do not express an opinion on the accompanying sustainability financial statements. Because of the significance of the matters described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the sustainability financial statements.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS), in accordance with the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States (*Government Auditing Standards*), and in accordance with the provisions of Office of Management and Budget (OMB) Bulletin No. 24-02, *Audit Requirements for Federal Financial Statements*. Our responsibilities under those standards and the provisions of OMB Bulletin No. 24-02 are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of HHS and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2024 and 2023, and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources for the years then ended.

Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts

As discussed in Note 25 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from, or on behalf of, the participants and estimated future expenditures to be paid to, or on behalf of, participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statement of social insurance and the related statement of changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA).

As further described in Note 26 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2024, 2023, 2022, 2021, and 2020, the current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections, using certain alternative payment provisions, intended to quantify the potential understatement of projected Medicare costs in future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 26, certain features of current law may result in some challenges for the Medicare program. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. As a result of these matters, we were unable to obtain sufficient audit evidence for the amounts presented in the statement of social insurance as of January 1, 2024, 2023, 2022, 2021 and 2020, and the related statement of changes in social insurance amounts for the periods ended January 1, 2024 and 2023.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibilities for the Audit of the Financial Statements

Except as described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report, our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-02 will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-02, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks.

Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about HHS's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis and Required Supplementary Information, as identified on HHS's Agency Financial Report Table of Contents, be presented to supplement the financial statements. Such information is the responsibility of management and, although not a part of the financial statements, is required by the Federal Accounting Standards Advisory Board, who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We were unable to apply certain limited procedures to the Required Supplementary Information related to the sustainability financial statements in accordance with GAAS because of the significance of the matters described in the Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts section of our report. We do not express an opinion or provide any assurance on the Required Supplementary Information related to the sustainability financial statements. We have applied certain limited procedures to the Management's Discussion and Analysis and other required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Financial Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The Other Financial Information, as identified on HHS's Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Information

Management is responsible for the other information included in the Agency Financial Report. The other information comprises the Message from the Secretary, About the Agency Financial Report, Message from the Office of the Assistant Secretary for Financial Resources, Summary of Financial Statement Audit and Management Assurances, Civil Monetary Penalty Adjustment for Inflation, Grants Closeout Reporting, Payment Integrity Report, FY 2024 Top Management and Performance Challenges Identified by the Office of Inspector General, Department's Response to the Office of Inspector General, and Section 4: Appendices, as identified on HHS's Agency Financial Report Table of Contents, but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 14, 2024 on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of HHS's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting and compliance.

Building a better working world

Ernst & Young LLP

November 14, 2024

Ernst & Young LLP
Suite 310
1201 Wills Street
Baltimore, MD 21231

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited, in accordance with auditing standards generally accepted in the United States of America, the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*) and the provisions of Office of Management and Budget (OMB) Bulletin No. 24-02, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2024, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes (collectively referred to as the "financial statements"), and our report dated November 14, 2024 expressed an unmodified opinion thereon. We also were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2024, and the related statement of changes in social insurance amounts for the period ended January 1, 2024, and the related notes (collectively referred to as the "sustainability financial statements"), and our report dated November 14, 2024 disclaims an opinion on the sustainability financial statements because of the significance of the matters described in the Basis for Disclaimer of Opinion section of our Report of Independent Auditors as we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on these statements.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS's internal control. We did not consider all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982 (FMFIA), such as those controls relevant to preparing performance information and ensuring efficient operations.

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

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We identified certain deficiencies in internal control described below that we consider to be significant deficiencies.

Significant Deficiencies

Financial Reporting Systems, Analysis and Oversight

Our review of internal control disclosed a series of deficiencies in financial systems and processes for producing financial statements. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required.

Inconsistencies in Financial Adjustment Compliance

As identified in our previous years, HHS recorded a significant number of nonstandard journal vouchers for entries that are unable to be posted through routine systematic processing. These entries consist of nonstandard postings to record both the proprietary and budgetary effects of certain financial activities for which either the financial system is not configured properly to post automatically or to post differences identified during the various reconciliations or analyses performed by HHS personnel. In response to this finding, HHS issued a Financial Adjustments Policy (the "Policy") in FY 2023. The Policy aids in identifying minimum requirements for preparing, reviewing, approving, classifying, posting, and monitoring financial adjustments to standardize the process consistently across HHS. In FY 2024, HHS issued interim guidance to assist Operating Divisions in standardizing and categorizing financial adjustments to comply with the Policy. HHS made significant progress in identifying populations of transactions and analyzing those transactions quarterly to classify the entries as standard versus non-standard. However, our procedures revealed that some Operating Divisions were not consistently classifying financial adjustment transactions into the appropriate categories (standard/nonstandard) or frequencies (recurring/nonrecurring) in accordance with the policy requirements.

HHS Procurement Processes

Over the past several years, HHS and our audit results have identified several concerns related to internal control and potential violations of laws and regulations related to procurement processes at both the HHS and the Operating Division levels. We have reported that HHS identified a series of potential violations to the *Antideficiency Act* (ADA) in the Report on Compliance and Other Matters section below. Those potential violations were identified several years ago, and HHS management indicated that during FY 2024, they have continued to go through reviews to determine if an ADA violation exists. Additionally, the HHS Office of Inspector General (OIG) reported that National Institutes of Health (NIH) did not close certain contracts in accordance with the Code of Federal Regulations. NIH concurred with the reported findings and indicated that corrective actions were underway.

Consistent with prior years, HHS and our audit results identified certain concerns related to accounting and reporting of procurement activities. For example, NIH currently leverages two separate purchase request information systems for acquisitions management, including one that is not integrated with the NIH Business System (NBS). While the NBS Purchase Request Information System Management (PRISM) supports 26 NIH institutes and centers (ICs), the Contract Award Management System (CAMS) is a stand-alone purchase request information system with the National Heart, Lung, and Blood Institute (NHLBI). The NBS PRISM, which is fully integrated with the NBS financial system, provides stringent controls across acquisition and financial management. The CAMS is not integrated and requires alternative methods and tools to transfer acquisitions data into NBS PRISM to interface with the NBS financial system. The dependency on nonintegrated third-party applications to transfer acquisitions data poses significant financial management and information security risks and increases the level of effort required to reconcile data between the two acquisition systems. NIH indicated that it has developed a multi-year corrective action plan to address the two instances of PRISM. The decommissioning of the second instance of PRISM is expected to occur in 2025. Although NIH continues to take certain steps to mitigate security risks and transition to a single procurement system, significant costs are associated with procuring and maintaining two PRISMs. These increased risks and additional costs would be nonexistent if NHLBI operated within the NBS PRISM. Additionally, there appear to be no functional, operational, or cost benefits to maintaining a separate PRISM that supports only one institute.

OMB Circular A-123 Program

To support federal agencies' required assertions under FMFIA, OMB issued Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control,* which requires agencies to annually assess risks that impact their ability to achieve operational and financial reporting objectives. It also prescribes a governance structure for (1) implementing the requirement to integrate risk management and internal control functions, (2) assessing the effectiveness of the environment and (3) reporting the level of reasonable assurance in an annual Statement of Assurance included in the respective Agency Financial Report.

As part of its process, HHS worked with its 13 Operating Divisions to communicate their responsibilities for OMB Circular A-123. Operating Divisions' responsibilities included: performing risk assessments, identifying, testing, and documenting key controls in end-to-end business processes, developing corrective action plans for identified control deficiencies, reporting findings to the departmental level, and supporting the development of their operating division level assurance statements which are used in the development of the HHS-wide statement. Although all 13 Operating Divisions performed certain procedures and provided assurances to the reasonableness of their environment, during our audit, we identified certain weaknesses related to the HHS FY 2024 OMB Circular A-123 program. For example:

- The Administration for Strategic Preparedness and Response (ASPR) provided an unqualified statement of reasonable assurance that its internal control and financial systems meet the objectives of the FMFIA within its annual Statement of Assurance. The Statement of Assurance stated that ASPR had evaluated its internal control and financial management systems to determine whether the objectives of FMFIA and OMB Circular A-123 were met, however, ASPR did not perform testing to assess the effectiveness of its internal control. During FY 2024, ASPR completed a risk assessment and updated cycle narratives for some of its significant processes. ASPR also performed quarterly reviews of its financial statements to confirm the completeness and accuracy of ASPR's balances and submitted the corresponding Certifications of Compliance. ASPR's work under OMB Circular A-123 was limited to the development of corrective action plans for the FY 2023 financial statement audit findings around inventory. The Department was unaware that ASPR had not performed the required OMB Circular A-123 testing.

- As part of our procedures, we reviewed the various Operating Division's control deficiency logs for each significant process. The control deficiency log is a summary of internal control deficiencies identified during the Operating Division's OMB Circular A-123 activities. For grant and contract-related deficiencies, we noted deficiencies dating back multiple years and at more than one Operating Division. Currently, HHS Departmental management indicated that they do not receive or review the control deficiency logs or related corrective action plans, a process that would allow monitoring of corrective actions and the ability to determine if findings are pervasive across HHS. HHS holds annual OMB Circular A-123 meetings and trainings with the Operating Divisions; however, deliverables from the Operating Division-level OMB Circular A-123 process to the Department solely centered on the Operating Division's interim and final Statement of Assurance.

Payment Integrity

The nature and volume of expenditures present a substantial challenge to HHS in the quantification, evaluation, and remediation of improper payments. To address the challenge, HHS has developed a series of processes throughout the agency to monitor, investigate, estimate, and report on improper payments. These processes include (1) identifying risk-susceptible programs through an annual risk assessment process, (2) estimating and reporting improper payment rates for those programs that are deemed risk-susceptible, (3) developing corrective actions to remediate

causes that result in improper payments, and (4) executing recovery activities to recoup improper payments. During FY 2024, although continued progress was noted, HHS continued to identify challenges that prevented the Department from meeting certain monitoring requirements of its programs for improper payments. For example:

- HHS developed, executed, and reported improper payments estimates for 11 of its 12 risk-susceptible programs. Management indicated that it is continuing its efforts to produce and report an estimate for each program deemed risk-susceptible in FY 2025.

- During FY 2024, the Department performed 89 program-specific risk assessments from the over 200 HHS programs whose annual outlays exceeded $10 million. A properly executed risk assessment process with appropriate criteria will assist management in focusing limited resources on those programs that are at a higher risk of having significant improper payments. As only 89 programs were assessed in fiscal year 2024 and a total of 188 were assessed in the three-year period ended fiscal year 2024, knowledge about potential susceptibility to significant improper payments may not be fully realized. The Payment Integrity Information Act of 2019 (PIIA) requires each agency to perform a risk assessment not less frequently than once every three fiscal years for each program and activity that exceeds $10 million of all reported program or activity payments made during that fiscal year. HHS indicated that it had limited resources which did not enable it to execute a full rotation of risk assessments based upon the required threshold. However, HHS plans to expand its assessment process to cover all programs whose outlays exceed $10 million by the end of FY 2025.

- The Administration for Children and Families (ACF) Office of Head Start annually awards over $10 billion in federal grants to approximately 1,800 recipients. In FY 2024, HHS reported that the Head Start program had an improper payment estimate above the PIIA statutory threshold of 10%. The reported rate of 11.98% was a significant increase over the FY 2023 rate reported which was 5.10%. ACF reported that the majority of the improper payments related to missing or insufficient documentation to substantiate certain payments.

- Since FY 2020, we reported that ACF had not calculated or published error rates for its Foster Care program. This was due to a four-year suspension of onsite Title IV-E Foster Care Eligibility Reviews due to the COVID-19 pandemic. The Title IV-E Review protocol is not conducted specifically for improper payment estimation but is instead governed by regulations authorizing federal monitoring of child welfare programs. HHS uses certain testing results from these reviews to calculate the Foster Care improper payment error rates. Generally, the process to capture all states' results takes three years with one third being visited annually. Each year the error rate is updated to include new data for the states visited that year. In FY 2024, ACF made significant progress in that it resumed its onsite reviews and testing for improper payments. In its first year, ACF performed reviews at six states judgmentally selected based on the date of the last review and other criteria and will report improper payments based on those initial reviews in the FY 2024 HHS Agency

Financial Report. HHS indicated that the estimate would not encompass the full population of states until FY 2026.

For the Centers for Medicare & Medicaid Services (CMS), health insurance claims and payments to private health plans under the Medicare Advantage program represent a substantial portion of CMS payments. These payments are complex and involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment, and concurrence with the cost to be paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating improper payment rates in programs deemed susceptible to significant improper payments: Medicare Fee-for-Service (Medicare FFS), Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicaid, Children's Health Insurance Program (CHIP) and the federally facilitated exchange component of the Advance Premium Tax Credit (APTC).

CMS remains committed to achieving reductions in all improper payment rates through various corrective actions. The eligibility component of the reported Medicaid and CHIP improper payment rates continues to be significantly impacted by flexibilities afforded by the COVID-19 Public Health Emergency (PHE), such as postponed eligibility determinations and eased requirements around provider enrollment/validations. While the Medicaid and CHIP improper payment rates continued to decline in the current year, including the CHIP improper payment rate falling below the statutory threshold of 10%, there is an increased risk that the rate could exceed this 10% threshold as these flexibilities expire. In addition, while management continued to implement corrective actions to reduce the Medicare FFS and APTC improper payment rates, the rates increased from the prior year.

CMS Oversight Processes

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on internal control, dated November 7, 2024. In that report, we outlined details of deficiencies noted and recommended improvements in its financial management controls. Consistent with our findings in the previous year, we concluded the aggregation of these deficiencies to be a significant deficiency for the CMS internal control over financial reporting. The following areas identified in the CMS current year audit merit continued focus.

Medicaid Entitlement Benefits Due and Payable

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the federal government. The federal government establishes the minimum requirements and provides oversight for the program, and the states design, implement, administer, and oversee their own Medicaid programs within the federal parameters.

In prior years, CMS completed the implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims, and encounters. As of the end of FY 2024, while data maintained within T-MSIS is utilized for operational purposes, management continues to evaluate the reliability and completeness of the claims-level information maintained within T-MSIS, prior to determining how this could be utilized in the financial accounting and reporting for Medicaid, and specifically Medicaid Entitlement Benefits Due and Payable (EBDP). CMS should continue to evaluate whether financial reporting risks can be addressed by using T-MSIS data to identify outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures that may require consideration in determining the Medicaid EBDP as of year-end, even if this data ultimately never becomes the basis for the EBDP estimate. Given the claims-level detail is not yet considered reliable for financial accounting and reporting, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid EBDP to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability calculated during prior periods which could serve to validate the continued use of a similar methodology. The Medicaid EBDP is a significant liability on the FY 2024 financial statements and is subject to volatility based on the complexity and judgment required in establishing this estimate. The lack of detailed claims data limits the ability to detect the impact of such a change, or other changes such as those related to the claims processing timing, on a timely basis or consider the potential impact of these items on the EBDP estimate, presenting a risk that potential updates to CMS's analysis will not be reflected in CMS's financial statements in a timely manner.

Medicare Entitlement Benefits Due and Payable

The estimate of retroactive settlements of cost reports is a portion of the EBDP liability for the Medicare program. This estimate includes amounts which may be due from or owed to providers for previous years' cost report for disproportionate share hospitals and teaching hospitals, as well as amounts which may be due/owed to hospitals for adjusted prospective payments. There are different departments within CMS involved in managing the cost report activity and developing the estimated liability without a defined process to verify the completeness and accuracy of the underlying data and to identify how changes in cost report activity impact the resulting estimate. In addition, CMS updated the reports utilized to develop this estimate during FY 2024, however, CMS continues to lack the ability to accumulate the detailed payment data in a way that would enable the isolation of outliers that exist in the cost report population that should be considered for the purposes of developing the EBDP estimate.

Statements of Social Insurance

The statements of social insurance (SOSI) for CMS present a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others

within CMS. The veracity of the underlying data remains critical to the accuracy of the model, and as a result the reviews of the underlying data is robust, in line with CMS's policies and procedures. As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including that which is generated from updating and running any macro in the spreadsheet, is checked by the reviewer. These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet or macro to ensure that the projection output from the program is as expected and reasonable. During our procedures, formula errors were identified that were not detected by the organization's monitoring and review function, and, accordingly, the related control was not functioning at the level of precision as designed.

Recommendations

We recommend that HHS continue to develop, refine, and adhere to its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. This will require focused efforts and continued prioritization of issues related to controls within and surrounding its financial information management systems. Specifically, we recommend the following:

- HHS should continue monitoring and oversight activities to ensure Operating Divisions comprehensive review of financial adjustment classification align with the Financial Adjustments Policy. Further, HHS should refine the definitions of standard, non-standard, recurring, and non-recurring entries within the Policy and the interim guidance. HHS should develop more robust monitoring and testing procedures to ensure the consistent application of the Policy across all Operating Divisions. Additionally, HHS should perform adequate review to ensure entries are classified appropriately (standard/nonstandard and recurring/nonrecurring). Operating Divisions should perform thorough analysis to identify root causes of high-risk adjustments and develop appropriate corrective actions to reduce the use of these type of adjustments (as outlined by the policy). Finally, HHS should continue to analyze the entries to determine if certain systems could be upgraded to allow for automated posting of standard/recurring transactions.

- HHS should continue to strengthen its processes related to acquisition activities. As potential internal control and law and regulation concerns are identified, we recommend that policies and procedures be updated with training provided to the acquisition personnel to provide assurances that processes are executed properly. Additionally, ongoing monitoring processes should be enhanced to provide effective internal controls so that anomalies can be prevented, identified, and remediated in a timely manner. Further, NIH should continue to implement corrective actions to provide for contract closeout in accordance with federal requirements. Finally, the NIH should transition to a single PRISM instance. Operating a stand-alone, non-integrated PRISM system poses significant risks and does not provide any cost benefit. In addition, maintaining a fully integrated acquisition system for 26 NIH ICs, then procuring and maintaining a second acquisition system for

only one component of NIH, raises questions about responsible stewardship of resources to administer acquisition activities at NIH.

- HHS should establish a process to evaluate whether pending ADA violations are reportable and report on a timely basis those items that are declared.

- HHS Operating Divisions should execute the required annual procedures to comply with the requirements of OMB Circular A-123. These procedures should include identifying key controls in the end-to-end business processes of all Divisions; testing and documenting key controls; developing corrective action plans; and reporting findings to the departmental level. Additionally, the Department should implement a process to monitor the operating division's' compliance with the requirements. This may include periodic reviews of an operating division's approach, the control deficiency logs, the corrective action plans, and other documentation as warranted to provide assurance that steps were properly completed.

- HHS should continue to enhance the monitoring of its programs for improper payments according to the required thresholds and consistent with the organization's objectives of improving payment accuracy levels. This will entail expanding risk assessments to additional programs above the $10 million threshold, developing estimation models for those programs where improper payment rates have not been developed and reported, and further identifying actions to reduce improper payments in the program for which rates exceed 10% or are trending in the wrong direction.

- We recommend that CMS continue to develop, refine, and adhere to its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. This would include having CMS:

    - Continue to evaluate how the Medicaid claims-level data can be refined to analyze trends at a claims level to enable the performance of robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the financial accounting and reporting of the Medicaid program.

    - Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology used to record this liability.

    - Continue to collaborate to assess the appropriateness of the data used to develop the cost report liability estimate and whether the resulting output of the methodology appears reasonable in light of current year activity. Continued focus in this area, including documentation of analyses performed should be documented prior to finalizing the estimate. In addition, develop a periodic validation of the completeness and accuracy of data that is included in these reports as part of maintaining a full suite of controls for this portion of the EBDP liability.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision. When changes are made, such as changes to the methodology or key assumptions, management should require an enhanced review specific to these changes.

Program Support Center

The HHS Program Support Center (PSC) is a shared services organization dedicated to providing support service to help HHS customers, including other Operating Divisions and other federal agencies, achieve mission-critical results. The PSC supports multiple service areas including financial management, occupational health, real estate and logistics, and grant management activities which has been reported to total more than 70% of grant expenditures for the federal government.

Beginning in FY 2023, HHS reported that the PSC had incurred significant turnover of personnel at all levels of the organization. As a stop gap measure during most of FY 2023, PSC engaged members of the HHS departmental staff to oversee the processing and closing of financial and budgetary activities. Although recruitment to fill openings occurred, the time required to fill those vacancies was longer than initially planned, leaving many positions unfilled for numerous months. As positions were filled during FY 2023 and FY 2024, appropriate transitions were not completed because succession plans knowledge transfer, documented policies, and cross-training of employees, was insufficient. Additionally, beginning in FY 2023 with continued ongoing audits and investigations in FY 2024, HHS reported its Payment Management System (PMS), which is used and monitored by the PSC, had improper payments to "bad actors."

The GAO's *Standards for Internal Control in the Federal Government* indicate that an internal control system should be a continuous built-in component of operations, effected by people, that provides reasonable assurance, that an entity's objectives will be achieved. However, during FY 2024 and 2023, our audits identified certain internal controls that, although designed correctly, were not executed timely, or controls were not being monitored sufficiently to identify errors, omissions, or incorrect information. For example:

- During FY 2024, the results of other audits and attestation engagements identified certain control deficiencies within the HHS's PSC Financial Management Portfolio, Payment Management Services' Payment Management System, and related processes, primarily related to grant management services. For example, the "Department of Health and Human Services Program Support Center, Financial Management Portfolio, Payment Management Services' Payment Management System for the period October 1, 2023 to June 30, 2024 report" indicated that certain reconciliations or reports were either not completed, not completed timely, or review and approval were not completed and documented through sign-off. Additionally, the report indicated that certain management review controls over PSC access to the PMS system, including active and separated individuals, were not completed timely.

- In connection with our testing of the budgetary balances, PSC responded to a questionnaire that included inquiries on how PSC monitors its budget activity, including allowances and obligations. PSC indicated that the process of monitoring its budgetary related activity was labor-intensive due to the use of manual processes and spreadsheets and that insufficient personnel were available to fully execute and oversee controls until technology updates are made and improved tools are developed. Additionally, consistent with the concerns outlined above, it was noted that continuity of skills-sets and resources to develop solutions was not available. PSC's Budget Office had turnover in the past few years and certain procedures were still being refined. For example, we noted within our test procedures, a lack of consistent monitoring of the status of funds across PSC. Although some Operating Divisions had implemented corrective actions to support consistent monitoring, we found the improved control activities had not been consistently applied across all Operating Divisions serviced by PSC.

- Late in the FY 2024 financial statement close process, the HHS Office of the Assistant Secretary for Financial Resources, Office of Finance identified discrepancies in multiple accounts when they were preparing the HHS Agency Financial Report. Follow-up by the team identified several entries totaling $609 million where the PSC had not properly recorded entries during the Operating Division's close period. For example, for several entries, PSC recorded the budgetary side of the entries using a nonstandard journal voucher but omitted posting to the proprietary side of the general ledger. PSC was required to update their trial balance and HHS was required to restate numerous amounts within its Agency Financial Report within days of issuance. When PSC was asked by HHS, they indicated that they were aware of the mistakes and thought it was resolved by posting the proprietary related entries in the next fiscal year. HHS management indicated that the team was impacted by limited resources and high turnover.

Recommendations

We recommend that PSC, working in conjunction with HHS' oversight:

- Analyze current PSC processes to identify organizational needs for executing and monitoring required controls, providing reasonable assurances that financial management information is accurate and reliable.

- Define and develop contingency plans for key roles to help the PSC address unexpected personnel changes that may impact internal controls over financial reporting.

- Develop written roles, responsibilities, and policies to mitigate succession risks. Clearly document each position's roles and responsibilities and develop operating procedures to verify personnel understand required processes and controls, including their frequency and deadlines. This will facilitate smooth transitions between personnel without delays.

- Strengthen budget monitoring activities by implementing consistent policies and controls to ensure reliable monitoring of status of funds.

- Strengthen financial close activities with stronger monitoring controls and training to ensure timely identification and communication of errors to the HHS Office of Finance.

- Develop and implement corrective action plans based on findings from ongoing audits and attestation engagements to address improper payments made to ineligible recipients that occurred in FY 2024.

Financial Information Systems

Information systems controls are a critical component of the federal government's operations to manage the integrity, confidentiality, and reliability of its programs and activities and assist with reducing the risk of errors, fraud, or other illegal acts. The nature, size, and complexity of the HHS's operations, usage of core and mixed systems for financial reporting and use of third-party service providers present a multitude of risks that need to be addressed and managed consistently from the top down.

HHS has a well-established governance body over the system that supports financial reporting activities. This governance body is proactive in issuing guidance to both core and mixed financial systems. In an effort to modernize its infrastructure many HHS systems, including CMS systems, have migrated their platform and infrastructure needs to cloud-based providers. With these changes in technical architecture, historical challenges related to the previous infrastructure have translated to new challenges in their cloud-based environment. HHS continues to update its previous business and information technology (IT) security processes as a result of these new infrastructures; however, new deficiencies were noted for FY 2024 in deficiency areas identified previously.

In addition to the financial statement audit for non-CMS systems, we have performed a separate financial statement audit of the CMS for FY 2024, and in conjunction with our reports on that audit, with recommendations specific to the CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions and are summarized herein.

As HHS continues its efforts to enhance its internal controls, the following items identified in the current year audit merit continued focus on the information systems controls and processes.

Controls Over Information System Access and Least Privileged Controls

HHS has a large number of users requiring access to HHS systems in order to process and record financial transactions. Accordingly, properly implemented system access controls, including user and system account management, segregation of duties, and monitoring of system access, are critical to preventing and detecting unauthorized usage of information resources and program and

data files. Without maintaining an appropriate level of access controls within HHS systems, the integrity of HHS information resources could be compromised.

Deficiencies continued to be identified in the implementation and monitoring of controls, including controls over system access to include access reviews. Examples identified for individual systems include:

- Provisioning and/or recertifying privileged access for key applications and underlying IT infrastructure was not consistently performed, and/or evidence of provisioning and/or recertifying activity was not retained.

- Logical access control procedures related to the timely removal of access for terminated personnel supporting CMS were not consistently followed.

- Insufficient controls over segregation of duties were identified including documenting all possible segregation of duties (SOD) conflicts on an approved matrix, identifying business justifications for all existing conflicts, implementing the necessary monitoring controls to mitigate known SOD risks, or implementing user access review controls to document waivers as appropriate.

Appropriate consideration over the design of controls for access and monitoring of access is essential to provide a suitable framework for subsequent implementation and operation of the controls. Without adequate controls over managing access to critical systems the risk of errors, the potential for fraud or other illegal acts is increased.

Recommendations

HHS should continue to improve the operating effectiveness of information security controls including access controls to validate that:

- Privileged access for key applications and the underlying IT infrastructure is in accordance with the principle of least privileged, monitored to detect and correct unauthorized access or activities.

- User access provisioning and reviews and recertification of access are being performed timely and by appropriate personnel with the requisite knowledge and experience of the employee access requirements and necessary system functionality. Additionally, evidence of provisioning/recertification should be retained.

- Non-CMS system segregation of duties controls are implemented fully as defined by system-specific implementation plans.

- CMS guidance and contractual requirements are followed for the separation of workforce personnel, including the removal of any associated user account for CMS IT systems and/or applications as well as facilities.

Additionally, HHS should continue developing and monitoring oversight procedures for third-party service organizations and define clear responsibilities within their system teams for performance of key IT security controls.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether HHS's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, as well as the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA), noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and, accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and the provisions of OMB Bulletin No. 24-02, which are described below and disclosed no instances of noncompliance in which HHS's financial management systems did not substantially comply with the Section 803 (a) requirements of FFMIA.

HHS's management determined that it may have potential violations of the ADA Act (31 United States Code chapters 13 and 15). For example, HHS identified potential violations related to (1) an obligation of funds for conference spending at the Food and Drug Administration and (2) certain contract obligations serviced by the PSC between FY 2006 and FY 2011 and the CMS occurring between FY 2014 and FY 2015. Additionally, PSC and NIH management were notified that they may have potential violations of the Federal Acquisition Regulation and the Code of Federal Regulations related to contracting matters. These potential violations are still being evaluated.

The Payment Integrity Information Act of 2019 (Public Law 116-117) (PIIA) (1) requires federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments for risk-susceptible programs and (2) establishes certain reporting requirements surrounding such programs and their related estimates. While the Department continues to make progress, HHS is not in full compliance with the requirements of the PIIA. For example:

- HHS has not performed risk assessments for all programs that exceed $10 million in annual outlays during the past three years, as defined within the PIIA.

- HHS has developed and reported improper payments for 11 of its 12 risk-susceptible programs. For the remaining risk-susceptible program, the Temporary Assistance for Needy Families (TANF) program, HHS is working to address various challenges to enable it to develop and report an improper payment estimate.

- Although HHS has calculated and reported an improper payment estimate for the federally facilitated exchange of the advance premium tax credit program, it has not calculated and reported an improper payment estimate for the state-based exchanges.

- HHS uses a three-year process to test all states in estimating an improper payment rate for its Foster Care Program. Because the process is in its first year, HHS indicated that it had not completed a full rotation of all states but generated an error rate based on the six states visited- an improvement over FY 2023 where no rate was available.

- Although HHS reported an improper payment rate for its Head Start program, the improper payment rate exceeded the statutorily required maximum of 10%.

- HHS is not in full compliance with the PIIA, as recovery activities of the identified improper payments for Medicare Part C program are delayed.

HHS's Response to Findings

Government Auditing Standards requires the auditor to perform limited procedures on HHS's response to the findings identified in our audit and described in the accompanying letter dated November 14, 2024. HHS's response was not subjected to the other auditing procedures applied in the audit of the financial statements and accordingly, we express no opinion on the response.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and the compliance and results of that testing and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 14, 2024

Department's Response to the Report of the Independent Auditors

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
Office of the Assistant Secretary for Financial Resources
Washington, D.C. 20201

To: Christi A. Grimm, Inspector General

From: Lisa Molyneux, Principal Deputy Assistant Secretary for Financial Resources performing the delegable duties of the Assistant Secretary for Financial Resources

Subject: Fiscal Year 2024 Independent Auditors' Financial Statement Audit Reports

Thank you for the opportunity to comment on the Fiscal Year 2024 Independent Auditors' Reports. We value and respect the continued dedication and thoroughness demonstrated by the Office of Inspector General (OIG) and its independent auditors, Ernst & Young, LLP (EY), throughout the audit of the Department of Health and Human Services' financial statements.

We are pleased the auditors confirmed the Department's financial health with an unmodified opinion on our principal financial statements. We acknowledge the disclaimers on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. We generally concur with the findings in the Report on Internal Control and Compliance, and we will work to identify root causes of noted deficiencies and take corrective actions. Our joint efforts will strengthen our controls and improve operations.

We would like to thank both the OIG and EY for your partnership. We take great pride in our achievements and remain steadfast in our commitment to enhancing stewardship, integrity, and transparency through ongoing collaboration with the OIG.

/Lisa Molyneux/

Lisa Molyneux
Principal Deputy Assistant Secretary for Financial Resources, performing the delegable duties of the Assistant Secretary for Financial Resources
November 14, 2024

Principal Financial Statements

U.S. Department of Health and Human Services

Consolidated Balance Sheets

As of September 30, 2024 and 2023

(in Millions)

	2024	2023
Assets (Note 2)		
Intragovernmental Assets:		
Fund Balance with Treasury (Note 3)	$ 676,944	$ 695,639
Investments, Net (Note 4)	406,589	360,380
Accounts Receivable, Net (Note 5)	783	786
Advances and Prepayments (Note 8)	2,830	2,552
Total Intragovernmental Assets	**1,087,146**	**1,059,357**
Other than Intragovernmental Assets:		
Accounts Receivable, Net (Note 5)	38,493	39,196
Inventory and Related Property, Net (Note 6)	19,302	27,829
Property, Plant and Equipment, Net (Note 7)	9,267	8,399
Advances and Prepayments (Note 8)	46	45,177
Other Assets:		
Loans Receivable, Net	410	501
Other	10	10
Total Other than Intragovernmental Assets	**67,528**	**121,112**
Total Assets	**$ 1,154,674**	**$ 1,180,469**
Stewardship Land (Note 21)		
Liabilities (Note 9)		
Intragovernmental Liabilities:		
Accounts Payable	$ 1,539	$ 1,576
Debt (Note 10)	1,091	3,272
Advances from Others and Deferred Revenue	442	372
Other Liabilities (Note 14)	1,636	1,570
Total Intragovernmental Liabilities	**4,708**	**6,790**
Other than Intragovernmental Liabilities:		
Accounts Payable	1,632	1,802
Entitlement Benefits Due and Payable (Note 11)	141,597	159,543
Federal Employee Salary, Leave, and Benefits Payable (Note 12)	1,512	1,279
Pensions and Post-Employment Benefits Payable (Note 12)	21,129	19,389
Environmental and Disposal Liabilities	453	384
Advances from Others and Deferred Revenue	4,156	3,245
Other Liabilities:		
Accrued Liabilities (Note 13)	17,171	17,435
Contingencies and Commitments (Note 15)	14,987	27,488
Other Liabilities (Note 14)	4,631	625
Total Other than Intragovernmental Liabilities	**207,268**	**231,190**
Total Liabilities	**211,976**	**237,980**
Net Position		
Unexpended Appropriations – Funds from Dedicated Collections (Note 20)	263,916	275,307
Unexpended Appropriations – Funds from Other Than Dedicated Collections	319,995	326,214
Total Unexpended Appropriations	**583,911**	**601,521**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 20)	348,049	325,042
Cumulative Results of Operations – Funds from Other Than Dedicated Collections	10,738	15,926
Total Cumulative Results of Operations	**358,787**	**340,968**
Total Net Position	**942,698**	**942,489**
Total Liabilities and Net Position	**$ 1,154,674**	**$ 1,180,469**

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

U.S. Department of Health and Human Services
Consolidated Statements of Net Cost
For the Years Ended September 30, 2024 and 2023
(in Millions)

	2024	2023
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	$ 1,684,513	$ 1,654,047
Earned Revenue	(163,913)	(154,882)
CMS Net Cost of Operations	1,520,600	1,499,165
Other Segments:		
Administration for Children and Families (ACF)	82,404	87,942
Administration for Community Living (ACL)	2,995	3,002
Agency for Healthcare Research and Quality (AHRQ)	365	353
Administration for Strategic Preparedness and Response (ASPR)	951	-
Centers for Disease Control and Prevention (CDC)	18,784	17,841
Food and Drug Administration (FDA)	7,247	6,686
Health Resources and Services Administration (HRSA)	14,305	15,390
Indian Health Service (IHS)	10,937	10,117
National Institutes of Health (NIH)	48,877	46,537
Office of the Secretary (OS)	26,135	23,919
Program Support Center (PSC)	2,728	2,977
Substance Abuse and Mental Health Services Administration (SAMHSA)	8,904	8,290
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	224,632	223,054
Actuarial (Gains) and Losses Commissioned Corps Retirement and Medical Plan Assumption Changes (Note 12)	977	(267)
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	225,609	222,787
Earned Revenue	(6,890)	(7,009)
Other Segments Net Cost of Operations	218,719	215,778
Net Cost of Operations (Note 22)	**$ 1,739,319**	**$ 1,714,943**

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

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position

For the Year Ended September 30, 2024

(in Millions)

	Funds from Dedicated Collections (Note 20)	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balances	$ 275,307	$ 326,214	$ -	$ 601,521
Appropriations Received	579,570	917,522	-	1,497,092
Appropriations Transferred in/out	-	(1,435)	-	(1,435)
Other Adjustments	(76,110)	(85,621)	-	(161,731)
Appropriations Used	(514,851)	(836,685)	-	(1,351,536)
Net Change in Unexpended Appropriations	(11,391)	(6,219)	-	(17,610)
Total Unexpended Appropriations	**$ 263,916**	**$ 319,995**	**$ -**	**$ 583,911**
Cumulative Results of Operations:				
Beginning Balances	$ 325,042	$ 15,926	$ -	$ 340,968
Adjustments (+/-)				
Correction of Errors (+/-)	-	231	-	231
Beginning Balances, as Adjusted	325,042	16,157	-	341,199
Appropriations Used	514,851	836,685	-	1,351,536
Nonexchange Revenue:				
Nonexchange Revenue – Tax Revenue	391,904	-	-	391,904
Nonexchange Revenue – Investment Revenue	10,627	1,184	-	11,811
Nonexchange Revenue – Other	3,135	242	-	3,377
Donations and Forfeitures of Cash and Cash Equivalents	85	-	-	85
Transfers in/out without Reimbursement	(5,523)	4,112	-	(1,411)
Donations and Forfeitures of Property	-	5	-	5
Imputed Financing	124	1,283	(360)	1,047
Other	-	(1,447)	-	(1,447)
Net Cost of Operations	892,196	847,483	(360)	1,739,319
Net Change in Cumulative Results of Operations	23,007	(5,419)	-	17,588
Total Cumulative Results of Operations	**$ 348,049**	**$ 10,738**	**$ -**	**$ 358,787**
Net Position	**$ 611,965**	**$ 330,733**	**$**	**$ 942,698**

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

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2023
(in Millions)

	Funds from Dedicated Collections (Note 20)	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 178,704	$ 374,265	$ -	$ 552,969
Appropriations Received	593,543	896,208	-	1,489,751
Appropriations Transferred in/out	-	(1,964)	-	(1,964)
Other Adjustments	(19,046)	(89,486)	-	(108,532)
Appropriations Used	(477,894)	(852,809)	-	(1,330,703)
Net Change in Unexpended Appropriations	96,603	(48,051)	-	48,552
Total Unexpended Appropriations	**$ 275,307**	**$ 326,214**	**$ -**	**$ 601,521**
Cumulative Results of Operations:				
Beginning Balances	$ 346,199	$ 2,937	$ -	$ 349,136
Appropriations Used	477,894	852,809	-	1,330,703
Nonexchange Revenue:				
Nonexchange Revenue – Tax Revenue	362,511	-	-	362,511
Nonexchange Revenue – Investment Revenue	9,869	805	-	10,674
Nonexchange Revenue – Other	3,243	220	-	3,463
Donations and Forfeitures of Cash and Cash Equivalents	64	-	-	64
Transfers in/out without Reimbursement	(5,018)	4,487	-	(531)
Donations and Forfeitures of Property	-	72	-	72
Imputed Financing	80	1,073	(356)	797
Other	(27)	(951)	-	(978)
Net Cost of Operations	869,773	845,526	(356)	1,714,943
Net Change in Cumulative Results of Operations	(21,157)	12,989	-	(8,168)
Total Cumulative Results of Operations	**$ 325,042**	**$ 15,926**	**$ -**	**$ 340,968**
Net Position	**$ 600,349**	**$ 342,140**	**$**	**$ 942,489**

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

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2024 and 2023
(in Millions)

	2024	2023
Budgetary Resources		
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory) (Note 16)	$ 404,006	$ 357,657
Appropriations (Discretionary and Mandatory)	2,438,861	2,460,478
Borrowing Authority (Discretionary and Mandatory)	86	-
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	21,618	23,268
Total Budgetary Resources (Note 23)	**$ 2,864,571**	**$ 2,841,403**
Status of Budgetary Resources		
New Obligations and Upward Adjustments (Note 23)	$ 2,518,745	$ 2,475,687
Unobligated Balance, End of Year:		
Apportioned, Unexpired Accounts	61,406	143,887
Exempt from Apportionment, Unexpired Accounts	1,657	1,821
Unapportioned, Unexpired Accounts	19,327	20,574
Unexpired Unobligated Balance, End of Year	82,390	166,282
Expired Unobligated Balance, End of Year	263,436	199,434
Unobligated Balance, End of Year	345,826	365,716
Total Budgetary Resources (Note 23)	**$ 2,864,571**	**$ 2,841,403**
Outlays, Net		
Outlays, Net (Discretionary and Mandatory)	$ 2,421,864	$ 2,368,288
Distributed Offsetting Receipts	(700,865)	(659,662)
Agency Outlays, Net (Discretionary and Mandatory) (Note 22)	**$ 1,720,999**	**$ 1,708,626**
Disbursements, Net	**$ 71**	**$ (70)**

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

U.S. Department of Health and Human Services
Statement of Social Insurance (Unaudited)

75-Year Projection as of January 1, 2024 and Prior Base Years
(in Billions)

	2024	Estimates from Prior Years 2023	2022	2021	2020
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 25 and 26)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 16,189	$ 15,360	$ 14,767	$ 13,029	$ 12,454
SMI Part B	40,323	39,008	39,039	34,467	32,165
SMI Part D	7,097	6,865	7,372	6,881	6,975
Have attained eligibility age (age 65 or over)					
HI	953	862	793	664	637
SMI Part B	8,181	7,683	7,447	6,536	5,864
SMI Part D	1,517	1,315	1,164	1,061	1,016
Those expected to become participants					
HI	15,360	15,046	14,603	13,017	12,464
SMI Part B	10,161	9,934	10,131	9,010	8,567
SMI Part D	2,393	2,372	3,094	2,921	3,043
All current and future participants					
HI	$ 32,502	$ 31,268	$ 30,163	$ 26,710	$ 25,554
SMI Part B	58,665	56,625	56,618	50,013	46,596
SMI Part D	11,008	10,551	11,630	10,863	11,035
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 25 and 26)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 22,970	$ 23,622	$ 23,211	$ 20,940	$ 20,103
SMI Part B	39,853	38,539	38,605	34,075	31,819
SMI Part D	7,097	6,865	7,372	6,881	6,975
Have attained eligibility age (age 65 and over)					
HI	7,357	7,215	7,010	6,230	6,073
SMI Part B	8,508	8,038	7,825	6,892	6,194
SMI Part D	1,517	1,315	1,164	1,061	1,016
Those expected to become participants					
HI	4,794	5,061	5,036	4,597	4,179
SMI Part B	10,304	10,048	10,188	9,046	8,583
SMI Part D	2,393	2,372	3,094	2,921	3,043
All current and future participants:					
HI	$ 35,120	$ 35,897	$ 35,257	$ 31,767	$ 30,355
SMI Part B	58,665	56,625	56,618	50,013	46,596
SMI Part D	11,008	10,551	11,630	10,863	11,035
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 25 and 26)					
HI	$ (2,618)	$ (4,630)	$ (5,094)	$ (5,057)	$ (4,800)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 25 and 26)					
HI	$ (2,618)	$ (4,630)	$ (5,094)	$ (5,057)	$ (4,800)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	209	198	177	198	195
SMI Part B	172	194	163	133	100
SMI Part D	16	18	20	10	9
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 25 and 26)					
HI	$ (2,410)	$ (4,432)	$ (4,917)	$ (4,859)	$ (4,606)
SMI Part B	172	194	163	133	100
SMI Part D	16	18	20	10	9

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Social Insurance (Continued) (Unaudited)

75-Year Projection as of January 1, 2024 and Prior Base Years
(in Billions)

		Estimates from Prior Years			
	2024	2023	2022	2021	2020
Medicare Social Insurance Summary					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 10,651	$ 9,860	$ 9,404	$ 8,261	$ 7,517
Expenditures	17,383	16,567	15,998	14,184	13,284
Income less expenditures	(6,731)	(6,707)	(6,595)	(5,922)	(5,766)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	63,609	61,232	61,178	54,377	51,594
Expenditures	69,920	69,026	69,188	61,895	58,897
Income less expenditures	(6,310)	(7,794)	(8,010)	(7,519)	(7,303)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(13,042)	(14,501)	(14,605)	(13,441)	(13,069)
Combined Medicare Trust Fund assets at start of period	397	410	360	341	303
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (12,645)	$ (14,091)	$ (14,244)	$ (13,100)	$ (12,766)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	$ 27,914	$ 27,352	$ 27,828	$ 24,948	$ 24,074
Expenditures	17,491	17,480	18,318	16,564	15,805
Income less expenditures	10,423	9,871	9,510	8,384	8,269
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(2,618)	(4,630)	(5,094)	(5,057)	(4,800)
Combined Medicare Trust Fund assets at start of period	397	410	360	341	303
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (2,222)	$ (4,220)	$ (4,734)	$ (4,716)	$ (4,497)

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Unaudited)

January 1, 2023 to January 1, 2024

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 27)					
As of January 1, 2023	$ 98,444	$ 103,074	$ (4,630)	$ 410	$ (4,220)
Reasons for change					
Change in the valuation period	2,839	2,983	(144)	(13)	(157)
Change in projection base	944	197	747	(1)	746
Changes in the demographic assumptions	(34)	664	(698)	-	(698)
Changes in economic and healthcare assumptions	(3)	(2,109)	2,106	-	2,106
Changes in law	(16)	(16)	-	-	-
Net changes	3,731	1,719	2,011	(13)	1,998
As of January 1, 2024	$ 102,175	$ 104,793	$ (2,618)	$ 397	$ (2,222)
HI - Part A (Note 27)					
As of January 1, 2023	$ 31,268	35,897	(4,630)	198	(4,432)
Reasons for change					
Change in the valuation period	815	959	(144)	4	(140)
Change in projection base	413	(334)	747	7	755
Changes in the demographic assumptions	(561)	137	(698)	-	(698)
Changes in economic and healthcare assumptions	567	(1,539)	2,106	-	2,106
Changes in law	-	-	-	-	-
Net changes	1,234	(777)	2,011	11	2,023
As of January 1, 2024	$ 32,502	$ 35,120	$ (2,618)	$ 209	$ (2,410)
SMI - Part B (Note 27)					
As of January 1, 2023	$ 56,625	$ 56,625	$ -	$ 194	$ 194
Reasons for change					
Change in the valuation period	1,728	1,728	-	(9)	(9)
Change in projection base	115	115	-	(13)	(13)
Changes in the demographic assumptions	129	129	-	-	-
Changes in economic and healthcare assumptions	84	84	-	-	-
Changes in law	(16)	(16)	-	-	-
Net changes	2,040	2,040	-	(22)	(22)
As of January 1, 2024	$ 58,665	$ 58,665	$ -	$ 172	$ 172
SMI - Part D (Note 27)					
As of January 1, 2023	$ 10,551	$ 10,551	$ -	$ 18	$ 18
Reasons for change					
Change in the valuation period	296	296	-	(7)	(7)
Change in projection base	416	416	-	4	4
Changes in the demographic assumptions	398	398	-	-	-
Changes in economic and healthcare assumptions	(653)	(653)	-	-	-
Changes in law	-	-	-	-	-
Net changes	456	456	-	(3)	(3)
As of January 1, 2024	$ 11,008	$ 11,008	$ -	$ 16	$ 16

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

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Continued) (Unaudited)

January 1, 2022 to January 1, 2023

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 27)					
As of January 1, 2022	$ 98,410	$ 103,504	$ (5,094)	$ 360	$ (4,734)
Reasons for change					
Change in the valuation period	2,206	2,331	(124)	(2)	(126)
Change in projection base	(1,961)	(3,148)	1,186	52	1,238
Changes in the demographic assumptions	(375)	(60)	(315)	-	(315)
Changes in economic and healthcare assumptions	2,873	3,156	(283)	-	(283)
Changes in law	(2,709)	(2,710)	1	-	1
Net changes	34	(431)	465	50	515
As of January 1, 2023	$ 98,444	$ 103,074	$ (4,630)	$ 410	$ (4,220)
HI - Part A (Note 27)					
As of January 1, 2022	$ 30,163	35,257	(5,094)	177	(4,917)
Reasons for change					
Change in the valuation period	571	696	(124)	(5)	(129)
Change in projection base	(174)	(1,361)	1,186	25	1,212
Changes in the demographic assumptions	(115)	200	(315)	-	(315)
Changes in economic and healthcare assumptions	824	1,107	(283)	-	(283)
Changes in law	-	(1)	1	-	1
Net changes	1,105	641	465	21	485
As of January 1, 2023	$ 31,268	$ 35,897	$ (4,630)	$ 198	$ (4,432)
SMI - Part B (Note 27)					
As of January 1, 2022	$ 56,618	$ 56,618	$ -	$ 163	$ 163
Reasons for change					
Change in the valuation period	1,355	1,355	-	13	13
Change in projection base	(2,135)	(2,135)	-	18	18
Changes in the demographic assumptions	(330)	(330)	-	-	-
Changes in economic and healthcare assumptions	2,386	2,386	-	-	-
Changes in law	(1,269)	(1,269)	-	-	-
Net changes	7	7	-	31	31
As of January 1, 2023	$ 56,625	$ 56,625	$ -	$ 194	$ 194
SMI - Part D (Note 27)					
As of January 1, 2022	$ 11,630	$ 11,630	$ -	$ 20	$ 20
Reasons for change					
Change in the valuation period	280	280	-	(10)	(10)
Change in projection base	348	348	-	8	8
Changes in the demographic assumptions	71	71	-	-	-
Changes in economic and healthcare assumptions	(337)	(337)	-	-	-
Changes in law	(1,440)	(1,440)	-	-	-
Net changes	(1,079)	(1,079)	-	(1)	(1)
As of January 1, 2023	$ 10,551	$ 10,551	$ -	$ 18	$ 18

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

Notes to the Principal Financial Statements

Note 1. Reporting Entity and Summary of Significant Accounting Policies

A. Reporting Entity

The United States (U.S.) Department of Health and Human Services (HHS or the Department) is a Cabinet-level agency within the executive branch of the federal government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* was signed into law. The law established a new federal entity, the Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The accompanying financial statements include activities and operations of the HHS. In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, HHS has included all consolidation entities it is accountable for in this general purpose federal financial report. The Office of the Secretary (OS) and 12 Operating Divisions (OpDivs) listed below are consolidated in the HHS financial statements. HHS conducted a systematic and thorough review of all organizations and determined HHS does not have any disclosure entities.

Organization and Structure of HHS

Each HHS OpDiv is responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center (PSC) is a responsibility segment and reports separately due to the business activities conducted on behalf of other federal agencies and HHS OpDivs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) and Advanced Research Projects Agency for Health (ARPA-H) is combined with the National Institutes of Health (NIH) for financial reporting purposes. On July 22, 2022, the Office of the Assistant Secretary for Preparedness and Response was elevated from a Staff Division to an OpDiv, creating the Administration for Strategic Preparedness and Response (ASPR). Starting in FY 2024, ASPR is presented as an OpDiv for financial reporting. Responsibility segment management report directly to the Department's top management, and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 13 responsibility segments are:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Administration for Strategic Preparedness and Response (ASPR)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS)
- Program Support Center (PSC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

CMS, the largest HHS OpDiv, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other health-related programs. CMS is also a separate reporting entity. The CMS annual financial report can be found at CMS.gov (unaudited).

B. Basis of Accounting and Presentation

HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515(b), the *Chief Financial Officers Act of 1990* (CFO Act), as amended by the *Government Management Reform Act of 1994*, and presented in accordance with the requirements in Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These financial statements have been prepared from HHS's financial records in conformity with accounting principles generally accepted in the U.S. The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants as federal GAAP. Therefore, these statements are different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the use of budgetary resources.

Transactions are recorded on accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned, and expenses are recognized when resources are consumed without regard to the payment of cash. Budgetary accounting principles are designed to recognize the obligation of funds according to legal requirements, which in many cases is prior to an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 224 appropriation accounts. These accounts are used for general government functions, collection of receipts, and suspense. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheets, Statements of Net Cost, and Statement of Changes in Net Position. The Statement of Budgetary Resources is represented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from that statement. Supplemental information is accumulated from the OpDivs, regulatory reports, and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

Accounting standards require all reporting entities to disclose that accounting standards allow certain presentations and disclosures to be modified, if needed, to prevent the disclosure of classified information.

C. Budgetary Terms

The purpose of federal budgetary accounting is to control, monitor, and report on funds made available to Federal agencies by law and help ensure compliance with the law. The following budget terms are commonly used.

Appropriations

Appropriations are a provision of law, not necessarily in an appropriations act, authorizing the expenditure of funds for a given purpose. Usually, but not always, an appropriation provides budget authority.

Budgetary Resources

Budgetary resources consist of new budget authority and unobligated balances from prior year budget authority and are available for obligation in a given year.

Offsetting Collections

Offsetting collections are payments to the Government, which by law are credited to expenditure accounts and deducted from gross budget authority and outlays of the expenditure account, rather than added to receipts. Offsetting collections are to be spent for the purposes of the account, usually without further action by Congress. They result from business-like transactions with the public (i.e., payments from the public in exchange for goods and services, reimbursements for damages, and gifts or donations of money to the Government) and from intragovernmental transactions.

Offsetting Receipts

Offsetting receipts are payments to the Government, which are credited to offsetting receipt accounts and deducted from gross budget authority and outlays, rather than added to receipts. Offsetting receipts are not authorized to be credited directly to expenditure accounts, since the legislation that authorizes the offsetting receipts may designate them for a specific purpose or appropriate them for expenditure for that purpose or require them to be appropriated in annual appropriations acts before they can be spent. Similar to offsetting collections, offsetting receipts usually result from business-like transactions with the public and from intragovernmental transactions with other Government accounts.

Obligations

An obligation is an action that creates a legal liability to disburse funds, immediately or in the future. Budgetary resources must be available before obligating actions can be taken legally. In entitlement programs, obligations may arise under operation of law.

Outlays

Outlays are payments to liquidate an obligation. Outlays generally are equal to cash disbursements. Outlays are the measure of Government spending. Net outlays are gross outlays reduced by offsetting collections.

D. Use of Estimates in Preparing Financial Statements

Financial statements prepared in accordance with GAAP are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist the reader in understanding the effect of changes in assumptions on the related information.

E. *Patient Protection and Affordable Care Act*

In FY 2010, the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* were signed and are collectively referred to as the PPACA. The PPACA contains the most significant changes to healthcare coverage since the *Social Security Act*.

Exchange Risk Adjustment Program

The Risk Adjustment program applies to non-grandfathered individual and small group plans inside and outside the Exchanges. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower-risk enrollees to plans with relatively higher-risk enrollees to protect against adverse selection. States that operate a State-based Exchange are eligible to establish a Risk Adjustment program. States operating a Risk Adjustment program may have an entity other than the Exchange perform this function. CMS operates a Risk Adjustment program for each state that does not operate its own Risk Adjustment program.

F. Parent/Child Reporting

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. HHS has allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations, and budget apportionments are derived.

Under the PPACA, HHS has established a child relationship with the Internal Revenue Service (IRS) of the U.S. Department of the Treasury (Treasury) for the payment of the advance premium tax credits to insurance providers. No financial activity is included in HHS's financial statements.

HHS also receives allocation transfers, as the child, from the Departments of Environmental Protection Agency, Justice, State, Treasury, and U.S. Agency for International Development. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of the Interior (DOI), Office of Personnel Management (OPM), Social Security Administration (SSA), and Departments of Commerce, Defense, Education, Labor (DOL), and Treasury.

G. Changes, Reclassifications and Adjustments

Reclassifications

The principal Balance Sheets, supplementary Balance Sheets, Statement of Budgetary Resources, and Combining Statement of Budgetary Resources, as well as some footnotes have changed to be in compliance with the OMB Circular A-136 and United States Standard General Ledger (USSGL) financial statement crosswalks. Thus, certain FY 2023 balances have been reclassified for comparability. For example, Federal Employee and Veteran Benefits Payable has been split into two lines Federal Salary, Leave, and Benefits Payable and Pensions and Post-Employment Benefits Payable. This also included an SGL account previously mapped to Other Liabilities which is now mapped to Federal Salary, Leave, and Benefits Payable.

H. Funds from Dedicated Collections

Funds from dedicated collections are generally financed by specifically identified revenues and provided to the government by non-federal sources. The sources are often supplemented by other financing sources, which remain available over time. Dedicated collections must meet the following criteria:

1. A statute committing the federal government to use specifically identified revenues and/or other financing sources that are originally provided to the federal government from a non-federal source only for designated activities, benefits, or purposes;
2. Explicit authority for the fund to retain revenues and/or other financing sources not used in the current period for future use to finance the designated activities, benefits, or purposes; and
3. A requirement to account for and report on the receipt, use, and retention of the revenues and/or other financing sources that distinguishes the dedicated collections from the federal government's general revenues.

HHS's major funds from dedicated collections are described in the sections below.

Medicare Hospital Insurance Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Medicare Hospital Insurance (HI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part A services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial

statements include HI trust fund activities administered by Treasury. The HI trust fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contribution Act* (FICA) and the *Self-Employment Contribution Act* (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the U.S. Government (general fund) to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports.

Medicare Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Supplementary Medical Insurance (SMI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part B services, as well as administrative costs, are charged to the SMI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority.

SMI benefits and administrative expenses are financed primarily by monthly premiums paid by Medicare beneficiaries with matching by the Federal government through the general fund appropriation, Payments to the Healthcare Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected and outlines the ratio for the match as the method to fully compensate the trust fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Supplementary Medical Insurance Trust Fund – Part D

The *Medicare Modernization Act of 2003*, established the Medicare Prescription Drug Benefit – Part D. Medicare also helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. In addition, the Low Income Subsidy helps those with limited income and resources.

The PPACA provided that beneficiary cost sharing in the Part D coverage gap be reduced for brand-name and generic drugs to a 25 percent coinsurance. Part D is considered part of the SMI trust fund and is reported in the SMI column of the financial statements.

Medicare and Medicaid Integrity Programs

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program at Section 1893 of the *Social Security Act*. HIPAA Section 201 also established the Healthcare Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program. The Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the *Deficit Reduction Act of 2005* (DRA) and codified at Section 1936 of the *Social Security Act*. The Medicaid Integrity Program represents the federal government's first national strategy to detect and prevent Medicaid fraud and abuse.

I. Revenue and Financing Sources

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriations and user fees. The U.S. Constitution prescribes that no money may be expended by an agency unless the funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred or assets are purchased. Revenues from reimbursable agreements are

recognized when the goods or services are provided by HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

Appropriations

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

Permanent Indefinite Appropriations

HHS permanent indefinite appropriations are open-ended; the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

Earned Revenue

Earned revenue results when HHS provides goods or services to another entity for a price and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

HHS pricing policy for reimbursable agreements is full cost recovery with no profit or loss for HHS. In addition to revenues related to reimbursable agreements, HHS collects various user fees to offset the cost of its services. Certain fees charged by HHS are based on amounts set by law or regulation and may not represent full cost.

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury Central Accounting Reporting System. Regardless of if they are derived from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate HHS use are deposited in the General Fund or HHS designated Special Funds. Amounts not retained for use by HHS are reported as Transfers in/out without Reimbursement to other government agencies on the HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

Non-exchange revenue results from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally enforceable claim to resources arises, but only to the extent that collection is probable, and the amount is reasonably estimable.

Non-exchange revenue is not considered to reduce the cost of the Department's operations and is separately reported on the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and SECA is considered non-exchange revenue.

Imputed Financing Sources

In certain instances, HHS's operating costs are paid out of funds appropriated to other federal entities. For example, by law, certain costs of retirement programs are paid by the OPM, and certain legal judgments against HHS are paid from the Judgment Fund maintained by Bureau of Fiscal Service (Fiscal Service), Treasury. When costs are identifiable to HHS, directly attributable to HHS's operations, and paid by other agencies, HHS recognizes these amounts as imputed costs within the Consolidated Statements of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

J. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions other than intragovernmental are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

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

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies, including SSA and Treasury. SSA determines eligibility for Medicare programs and deducts Medicare Part B premiums from Social Security benefit payments for beneficiaries who elect to enroll in the Medicare Part B program and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare Part B trust fund. Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Medicare Part D is primarily financed by the General Fund, as well as beneficiary premiums and payments from states.

K. Entity and Non-Entity Assets

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

Non-entity assets are assets held by the reporting entity, but not available for use. HHS non-entity assets are related to delinquent child support payments withheld from federal tax refunds for the Child Support Services program, interest accrued on over-payments, and cost settlements reported by the Medicare contractors.

L. Fund Balance with Treasury

The Fund Balance with Treasury is the aggregate amount of funds in the Department's accounts with Treasury. Fund Balance with Treasury is available to pay current liabilities and finance authorized purchases. Treasury processes cash receipts and disbursements for the Department's operations. HHS reconciles Fund Balance with Treasury accounts with Treasury on a regular basis.

M. Custodial Activity

HHS reports custodial activities on its Consolidated Balance Sheets in accordance with OMB Circular A-136. However, HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

ACF receives funding from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. FDA custodial activity involves collections of Civil Monetary Penalties that are assessed by the Department of Justice on behalf of the FDA. FDA is charged with assessing penalties for violations in areas such as illegally manufactured, marketed, and distributed animal food and drug products. CDC's custodial activity consists of the collection of interest on outstanding receivables and funds received from debts in collection status.

N. Investments, Net

HHS invests entity Medicare trust fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the U.S. Government's investments in securities. Sections 1817 and 1841 of the *Social Security Act* require that funds in the HI and SMI trust funds not needed to meet current expenditures be invested in interest-bearing obligations or in obligations guaranteed as to both principal and interest by the U.S. Government. The cash receipts, collected from the public as dedicated collections, are deposited with the Treasury, which uses the cash for general governmental purposes. Treasury securities are issued by the Fiscal Service to the HI and SMI trust funds as evidence of their receipt and are reported as an asset of the trust funds and a corresponding liability of the Treasury. The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI trust funds.

The Treasury securities provide the HI and SMI trust funds with authority to draw upon the Fiscal Service to make future benefit payments or other expenditures. When the trust funds require redemption of these securities to make expenditures, the government finances the expenditures by raising taxes, raising other receipts, borrowing from the public or repaying less debt, or curtailing other expenditures. This is the same way that the government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI trust funds are Non-Marketable (Par Value) securities. These investments are carried at face value as determined by the Fiscal Service. Interest income is compounded semi-annually (i.e., June and December) by the Fiscal Service, and at fiscal year-end, interest income is adjusted to include an accrual for interest earned from July 1 to September 30.

The Vaccine Injury Compensation trust fund, a dedicated collections fund similar to the HI and SMI trust funds, invests in Non-Marketable, Market-Based securities issued by the Fiscal Service in the form of One Day Certificates and Market-Based Bills, Notes, and Bonds.

The NIH Gift Funds are invested in Non-Marketable, Market-Based Securities issued by the Fiscal Service. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities since it is HHS's intent to hold investments to maturity.

O. Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible accounts. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. Accounts Receivable, Net from the public is primarily composed of provider and beneficiary over-payments: Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties, criminal restitution, state phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, Medicare Secondary Payer accounts receivable, and Marketplace activities.

Accounts Receivable, Net from the public is net of an allowance for uncollectible accounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past 5 years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the states. The other accounts receivable is comprised mostly of amounts due to HHS related to collections for Marketplace activities.

P. Advances and Prepayments and Accrued Liabilities

HHS recognizes grant expenses at the time of payment to the grant recipients. The accrual includes the incurred but not reported (IBNR) amount.

Formula grants and block grants are funded when grantees provide services or payments to individuals and local agencies from a fixed amount of money. These grants are funded based on allocations determined by budgets and agreements approved by the sponsoring OpDiv. The expenses are recorded as the grantees draw funds; no year-end accrual is required.

The standard Accelerated and Advance Payment (AAP) program was established to help providers and suppliers who are experiencing disruptions in cash flow due to system issues or claims processing delays. Standard AAPs are most commonly used during local emergencies, such as hurricanes or wildfires, which impact a provider or supplier's ability to submit or receive claims payments.

Q. Inventory and Related Property, Net

Inventory and Related Property, Net primarily consists of Stockpile Materials Held for Emergency and Contingency and Inventory Held for Sale or Use.

Stockpile Materials are Held in Reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the Strategic National Stockpile (SNS), Biomedical Advanced Research and Development Authority (BARDA), and Vaccines for Children (VFC). The stockpile contains several million doses of vaccine in bulk, which are stored and maintained for possible use.

Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the first-in/first-out (FIFO) for SNS and specific identification for VFC.

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

Inventory Held for Sale or Use includes Inventories Held for Sale and Operating Material and Supplies. Inventories Held for Sale consists of small equipment and supplies held by the Service and Supply Funds (SSF) for sale to HHS components and other federal entities. These inventories are valued at historical cost using the weighted average valuation method for the PSC's SSF inventories and using the moving average valuation method for the NIH's SSF inventories.

R. Property, Plant and Equipment, Net

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

The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. When property is acquired through a donation, the cost recognized is the estimated fair market value on

the date of acquisition. The cost of PP&E transferred from other federal entities is the transferring entity's net book value. Except for internal-use software, HHS capitalizes all PP&E with an initial acquisition cost of $100,000 or more and an estimated useful life of two years or more.

HHS has commitments under various operating leases with private entities, as well as the General Services Administration (GSA) for offices, laboratory space, and land. Leases with private entities have initial or remaining noncancelable lease terms from 1 to 50 years; however, some GSA leases are cancelable with 120-days notice. Under an operating lease, the cost of the lease is expensed as incurred.

In FY 2024, HHS implemented the requirements under SFFAS 54, *Leases*. HHS is required to report a right-to-use lease asset and a lease liability for non-intragovernmental, non-short-term contracts or agreements, when the entity has the right to obtain and control access to economic benefits or services from an underlying property, plant, or equipment asset for a period of time in exchange for consideration under the terms of the contract or agreement. HHS is required to report a right-to-use lease asset and a lease liability where HHS is a lessee, and a lease receivable and deferred revenue liability where HHS is the lessor.

An embedded lease is a contract or agreement that contains a lease and non-lease component, and the primary purpose is attributed to the non-lease component. In accordance with SFFAS 62, *Transitional Amendment to SFFAS 54*, HHS has elected to use the Transitional Accommodation for embedded leases through September 30, 2025, which allows for the embedded lease to be accounted for as non-lease through the accommodation period.

PP&E is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

In accordance with SFFAS 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's capitalization threshold for internal-use software costs for appropriated fund accounts is $1 million, and the threshold for revolving fund accounts is $500,000. Costs below the threshold levels are expensed. Software is amortized using the straight-line method over a period of 5 to 10 years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

S. Stewardship Land

HHS Stewardship Land (i.e., land not acquired for or in connection with PP&E) is Indian Trust land used to support the IHS day-to-day operations of providing healthcare to American Indians and Alaska Natives in remote areas of the country where no other facilities exist. In accordance with SFFAS 29*, Heritage Assets and Stewardship Land,* HHS does not report a related amount on the Consolidated Balance Sheets.

HHS asset accountability reports differentiate Indian Trust land parcels from PP&E situated thereon.

T. Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. HHS's liabilities are classified as covered by budgetary resources, not covered by budgetary resources, or not requiring budgetary resources.

Liabilities Covered by Budgetary Resources

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation, and borrowing authority.

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned but not taken, and amounts billed by the DOL for disability payments. The actuarial *Federal Employee Compensation Act* (FECA) liability determined by the DOL but not yet billed is also included in this category.

Liabilities Not Requiring Budgetary Resources

Clearing accounts, non-fiduciary deposit funds, custodial collections, and unearned revenue and liabilities that have not in the past required and will not in the future require use of budgetary resources.

U. Accounts Payable

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

V. Federal Employee Salary, Leave and Benefits Payable

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

W. Debt

HHS's debt to the Treasury is related to amounts borrowed to cover the accelerated and advance payments made for the AAP (CAAP) program. The *Continuing Appropriations Act, 2021 and Other Extensions Act* requires debt to Treasury for the AAP program to be repaid from collections (described in the Advances and Prepayments and Accrued Liabilities section of this note) on a periodic basis. In addition, HHS has debt for amounts borrowed to cover Medicare Part B premium shortfalls. The *Bipartisan Budget Act of 2015* (Section 601) authorized a transfer from the General Fund to SMI, to temporarily replace the reduction in Medicare Part B premiums for calendar years 2016 and 2017. Section 601 created an additional premium charged alongside the normal Medicare Part B monthly premiums, which will be used to pay back the general fund transfer without interest. The *Continuing Appropriations Act, 2021 and Other Extensions Act* (H.R. 8337 enacted on October 1, 2020) made similar changes for 2021. These repayments are transferred quarterly.

X. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

Y. Pensions and Post-Employment Benefits Payable

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan for its active-duty officers, retiree annuitants, and survivors. The plan does not have accumulated assets and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits on the Consolidated Balance Sheets. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end on the Statements of Net Cost.

The liability for Pensions and Other Post-Employment Benefits Payable also includes an actuarial liability for estimated future payments for workers' compensation pursuant to the FECA. FECA provides income and medical cost protection to federal employees who are injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by DOL, which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims billed by the DOL to agencies but not yet paid; and (2) an estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs. The claims that have been billed by DOL are included in Accrued Payroll and Benefits.

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

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

Z. Contingencies and Commitments

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

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

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

Treaties and other international agreements are written agreements between the U.S. and other sovereign states, or between the U.S. and international organizations, governed by international law. The Department of State developed and continues to manage the Circular 175 procedure (unaudited), which outlines the approval process for the negotiation and conclusion of international agreements which HHS will become a party. For reporting purposes HHS has no present or contingency obligation related to treaties and international agreements when entered into force.

HHS has no material obligations related to cancelled appropriations for which there is a contractual commitment for payment or for contractual arrangements which may require future financial obligations.

AA. Statement of Social Insurance (unaudited)

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

Note 2. Entity and Non-Entity Assets (in Millions)

	2024	2023
Non-Entity Intragovernmental Assets	$ 26	$ 85
Non-Entity Other than Intragovernmental Assets	70	48
Total Non-Entity Assets	96	133
Total Entity Assets	1,154,578	1,180,336
Total Assets	**$ 1,154,674**	**$ 1,180,469**

HHS reported a decrease of $25.8 billion in Total Entity Assets primarily due to changes in Advances and Prepayments, Fund Balance with Treasury, Investments, and Inventory and Related Property. Refer to the respective footnotes below for additional information.

Note 3. Fund Balance with Treasury (in Millions)

	2024	2023
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 63,063	$ 145,708
Unavailable	282,763	220,008
Obligated Balance not yet Disbursed	413,966	425,355
Non-Budgetary Fund Balance with Treasury	(82,848)	(95,432)
Total Fund Balance with Treasury	**$ 676,944**	**$ 695,639**

The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $43.2 billion as of September 30, 2024 ($42.9 billion as of September 30, 2023). The restricted amount is primarily for CHIP, CMS Program Management, Center for Medicare and Medicaid Innovation, and State Grants and Demonstrations.

The Unobligated Balance, Available decrease of $82.6 billion is primarily due to a decrease in appropriations for Payments to the Healthcare Trust Funds of $74.6 billion, reflecting the increase in expired year return of definite authority and current year return of indefinite authority, CHIP of $3.8 billion, and Other Health and Program management combined of $1.3 billion.

The Unobligated Balance, Unavailable increase of $62.8 billion is primarily due to Payments to Healthcare Trust Funds of $65.7 billion due to the increase in definite authority retained in the prior year, offset by a decrease in CHIP of $3.3 billion.

The Non-Budgetary Fund Balance with Treasury mostly represents amounts that have not yet been withdrawn from the Trust Funds.

Note 4. Investments, Net (in Millions)

	2024				
	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 399,372	$ -	$ 2,584	$ 401,956	$ 401,956
Non-Marketable: Market-Based	4,666	(45)	12	4,633	4,633
Total Intragovernmental	**$ 404,038**	**$ (45)**	**$ 2,596**	**$ 406,589**	**$ 406,589**

	2023				
	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 353,899	$ -	$ 2,030	$ 355,929	$ 355,929
Non-Marketable: Market-Based	4,503	(64)	12	4,451	4,451
Total Intragovernmental	**$ 358,402**	**$ (64)**	**$ 2,042**	**$ 360,380**	**$ 360,380**

HHS investments consist primarily of Medicare Trust Fund investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2026 through June 30, 2038 with interest rates ranging from 1.500 percent to 4.625 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2025 with interest rates ranging from 4.000 percent to 4.125 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in FY 2025 through FY 2026. The Market-Based Notes paid rates ranging from 0.375 percent to 3.875 percent during October 1, 2023 to September 30, 2024. The Market-Based Bonds pay 6.875 percent through FY 2025.

The Non-Marketable Market-Based Securities held in the NIH gift funds yielded rates ranging from 5.077 percent to 5.472 percent from October 1, 2023 through September 30, 2024 depending on date purchased and length of time to maturity.

Note 5. Accounts Receivable, Net (in Millions)

	2024				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 783	$ -	$ 783	$ -	$ 783
Total Intragovernmental	**$ 783**	**$**	**$ 783**	**$**	**$ 783**
Other than Intragovernmental					
Entity					
Medicare	$ 28,421	$ -	$ 28,421	$ (5,301)	$ 23,120
Medicaid	6,962	-	6,962	(766)	6,196
Other	10,868	455	11,323	(2,216)	9,107
Non-Entity	17	154	171	(101)	70
Total Other than Intragovernmental	**$ 46,268**	**$ 609**	**$ 46,877**	**$ (8,384)**	**$ 38,493**

	2023				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivables, Net
Intragovernmental					
Entity	$ 786	$ -	$ 786	$ -	$ 786
Total Intragovernmental	**$ 786**	**$**	**$ 786**	**$**	**$ 786**
Other than Intragovernmental					
Entity					
Medicare	$ 28,963	$ -	$ 28,963	$ (4,408)	$ 24,555
Medicaid	7,365	-	7,365	(787)	6,578
Other	9,335	383	9,718	(1,703)	8,015
Non-Entity	26	85	111	(63)	48
Total Other than Intragovernmental	**$ 45,689**	**$ 468**	**$ 46,157**	**$ (6,961)**	**$ 39,196**

Note 6. Inventory and Related Property, Net (in Millions)

	2024	2023
Inventory Held for Sale or Use	$ 1,199	$ 1,829
Stockpile Materials Held for Emergency or Contingency	18,103	26,000
Total Inventory and Related Property, Net	**$ 19,302**	**$ 27,829**

The Inventory and Related Property, Net decrease of $8.5 billion is primarily due to a decrease in Public Health and Social Services Emergency Fund (PHSSEF) of $7.3 billion related to BARDA therapeutics and vaccines, Paxlovid inventory, bulk drug substances, operating supplies, Ebola, and Project Bioshield inventories. Additionally, the *Defense Production Act* inventory decreased by $1.7 billion for therapeutics and vaccine testing, procurement, and distribution. These decreases were offset by a $0.3 billion increase in SNS and influenza vaccine inventory.

Note 7. Property, Plant and Equipment, Net (in Millions)

	Depreciation Method	Estimated Useful Lives	2024 Acquisition Cost	2024 Accumulated Depreciation	2024 Net Book Value
Land & Land Rights	N/A	N/A	$ 71	$ (11)	$ 60
Construction in Progress	N/A	N/A	2,465	-	2,465
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	7,324	(4,438)	2,886
Equipment	Straight-Line	3-20 Yrs	1,888	(973)	915
Internal Use Software	Straight-Line	5-10 Yrs	6,944	(4,803)	2,141
Assets Under Capital Lease	Straight-Line	1-30 Yrs	72	(61)	11
Leasehold Improvements	Straight-Line	*Life of Lease	44	(21)	23
Right-to-Use Lease	Straight-Line	*Life of Lease	815	(49)	766
Total			**$ 19,623**	**$ (10,356)**	**$ 9,267**

	Depreciation Method	Estimated Useful Lives	2023 Acquisition Cost	2023 Accumulated Depreciation	2023 Net Book Value
Land & Land Rights	N/A	N/A	$ 70	$ (5)	$ 65
Construction in Progress	N/A	N/A	1,793	-	1,793
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	7,158	(4,237)	2,921
Equipment	Straight-Line	3-20 Yrs	1,867	(929)	938
Internal Use Software	Straight-Line	5-10 Yrs	6,635	(3,983)	2,652
Assets Under Capital Lease	Straight-Line	1-30 Yrs	72	(59)	13
Leasehold Improvements	Straight-Line	*Life of Lease	34	(17)	17
Total			**$ 17,629**	**$ (9,230)**	**$ 8,399**

*7 to 15 years or the life of the lease, whichever is shorter.

	2024 Acquisition Cost	2024 Accumulated Depreciation	2024 PP&E, Net	2023 Acquisition Cost	2023 Accumulated Depreciation	2023 PP&E, Net
Balance Beginning of Year	$ 17,629	$ (9,230)	$ 8,399	$ 16,551	$ (8,275)	$ 8,276
Capitalized Acquisitions	1,277	-	1,277	1,158	(54)	1,104
Right-to-Use Lease Assets	815	-	815	-	-	-
Amortization of Right-to-Use Lease Assets	-	(49)	(49)	-	-	-
Dispositions	(98)	117	19	(80)	80	0
Depreciation Expense	-	(1,194)	(1,194)	-	(981)	(981)
Balance End of Year	**$ 19,623**	**$ (10,356)**	**$ 9,267**	**$ 17,629**	**$ (9,230)**	**$ 8,399**

As of September 30, 2024, HHS has recorded $0.8 billion in right-to-use lease assets primarily attributable to laboratory space and clinics. Additionally, HHS has right-to-use lease agreements based on delegated authority under the *Indian Health Care Improvement Act* (Public Law 94-437). The costs of these leases are nominal (typically no cost or one dollar), as they are leases between HHS and a Tribal Organization where the Tribe provides the building and HHS provides the healthcare services.

Note 8. Advances and Prepayments (in Millions)

	2024	2023
Intragovernmental		
Advances to Other Federal Entities	$ 2,830	$ 2,552
Total Intragovernmental	**$ 2,830**	**$ 2,552**
Other than Intragovernmental		
Prescription Drug and Medicare Advantage	$ -	$ 45,119
Grant Advances	22	42
Other	24	16
Total Other than Intragovernmental	**$ 46**	**$ 45,177**

The decrease of Other than Intragovernmental Advances and Prepayments of $45.1 billion is primarily due to timing of the FY 2023 Prescription Drug and Medicare Advantage benefit prepayments. The October 2023 payment occurred on September 29 instead of October 1, which was on a weekend.

Note 9. Liabilities Not Covered by Budgetary Resources (in Millions)

	2024	2023
Intragovernmental:		
Accrued Payroll and Benefits	$ 49	$ 46
Debt (Note 10)	604	2,854
Other	1,492	1,457
Total Intragovernmental	**$ 2,145**	**$ 4,357**
Federal Employee Benefits Payable	$ 22,177	$ 20,368
Contingencies and Commitments (Note 15)	14,987	27,488
Accrued Liabilities	8,430	7,750
Unfunded Lease Liability	764	-
Other	461	392
Total Liabilities Not Covered by Budgetary Resources	$ 48,964	$ 60,355
Total Liabilities Covered by Budgetary Resources	158,269	173,780
Total Liabilities Not Requiring Budgetary Resources	4,743	3,845
Total Liabilities	**$ 211,976**	**$ 237,980**

Liabilities Not Covered by Budgetary Resources had a decrease of $11.4 billion, mostly due to decreases in Contingencies of $12.5 billion and Debt of $2.3 billion. This is offset by increases in Federal Employee Benefits Payable of $1.8 billion, Unfunded Lease Liability of $0.8 billion, and Accrued Liabilities of $0.7 billion.

Note 10. Debt (in Millions)

	2023 Beginning Balance	2023 Net Borrowing	2023 Ending Balance	2024 Net Borrowing	2024 Ending Balance
Debt to the Treasury					
Transitional SMI Contribution	$ 4,863	$ (2,163)	$ 2,700	$ (2,214)	$ 486
COVID-19 Accelerated and Advance Payment Program	2,884	(2,730)	154	(36)	118
Other	509	(91)	418	69	487
Total Debt to the Treasury	**$ 8,256**	**$ (4,984)**	**$ 3,272**	**$ (2,181)**	**$ 1,091**

HHS has $1.1 billion ($3.3 billion as of September 30, 2023) in total debt due to Treasury. The *Balanced Budget Act of 2015* (Section 601) authorized a transfer from the general fund to SMI, to temporarily replace the reduction in Part B premiums for calendar years 2016 and 2017. Section 601 created an "additional premium" charged alongside the normal Part B monthly premiums, which will be used to pay back the general fund transfer without interest. The *Continuing Appropriations Act, 2021 and Other Extensions Act* (H.R. 8337 enacted on October 1, 2020) made similar changes for 2021. Debt of $0.5 billion ($2.7 billion as of September 30, 2023) is for amounts borrowed to cover the premium shortfalls. The decrease is due to the FY 2021 Transitional SMI advance repayments to Payments to the Healthcare Trust Funds of $2.2 billion.

Debt of $0.1 billion ($0.2 billion as of September 30, 2023) is related to amounts borrowed to cover the accelerated and advance payments made for the CAAP program. CAAP program repayments are based on collections.

Note 11. Entitlement Benefits Due and Payable (in Millions)

	2024	2023
Medicare Fee-For-Service	$ 61,125	$ 88,660
Medicare Advantage/Prescription Drug Program	27,707	17,560
Medicaid	51,460	52,028
CHIP	1,305	1,295
Total Entitlement Benefits Due and Payable	**$ 141,597**	**$ 159,543**

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

The Medicare fee-for-service liability is primarily an actuarial liability which represents: (1) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment; (2) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued; (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees; (4) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year; and (5) an estimate of retroactive settlements of cost reports. The September 30, 2024 and 2023 estimates also include amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals, as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment-related adjustments including the estimate for the first nine months of the calendar year 2024. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2024.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS based on data from the states' latest audited Comprehensive Annual Financial Report. Each state's estimate is subject to variability due to the variety of programs offered by the respective states and the data required to formulate these estimates. Accordingly, the ultimate outcome of these estimates could vary from the amounts recorded as of September 30, 2024 and 2023.

Note 12. Federal Employee Benefits Payable (in Millions)

	2024	2023
Federal Employee Salary, Leave, and Benefits Payable		
Unfunded Leave	$ 1,048	$ 979
Accrued Funded Leave and Payroll	460	291
Other	4	9
Total Federal Employee Salary, Leave, and Benefits Payable	**1,512**	**1,279**
Pensions and Other Post-Employment Benefits Payable		
PHS Commissioned Corps Pension Liability	$ 20,013	$ 18,325
PHS Commissioned Corps Post-Retirement Health Benefits	869	822
Workers' Compensation Benefits (Actuarial FECA Liability)	247	242
Total Pensions and Other Post Employment Benefits Payable	**$ 21,129**	**$ 19,389**

Public Health Service Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 5,376 active-duty officers, 65 individual ready reserve members, and 8,265 retiree annuitants and survivors. As of September 30, 2024, the actuarial accrued liability for the retirement benefit plan was $20.0 billion and $0.9 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commissioned Corps Retirement System and the Post-Retirement Medical Plan are not funded. Therefore, in accordance with SFFAS 33*, Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates*, the discount rate is based on long-term assumptions, for marketable securities (i.e., Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates are matched with the expected timing of the associated expected cash flow. A single discount rate may be used for all the projected cash flow, as long as the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2024 and September 30, 2023, were:

	2024	2023
Discount Rate	3.20 percent	3.15 percent
Annual Basic Pay Scale Increase	2.47 percent	2.38 percent
Annual Inflation	2.56 percent	2.22 percent

The table on the next page shows key valuation results as of September 30, 2024 and 2023, in conformance with the actuarial reporting standards set forth in the SFFAS 5 and SFFAS 33. The valuation is based upon the current plan provisions, membership data collected as of September 30, 2024, and actuarial assumptions. The September 30, 2024, valuation includes an increase in liabilities of $1.7 billion resulting from changes in the assumed annual inflation rate, in the assumed salary scale, and in the assumed discount rate. These changes in combination with the actual plan experience over the past year (based upon new census data), resulted in an overall net increase in the actuarial accrued liability as compared to the prior valuation. The annual expense for the Retirement Benefit Plan for FY 2024 has increased relative to the prior year expense.

	2024	2023
Beginning Liability Balance	$ 19,147	$ 18,202
Expense		
Normal Cost	499	490
Interest on the Liability Balance	591	574
Actuarial (Gain)/Loss		
From Experience	420	862
From Assumption Changes		
Change in Discount Rate Assumption	(161)	210
Change in Inflation/Salary Increase Assumption	1,023	(544)
Change in New Medical Trends Assumption	33	48
Change in Others	82	19
Total From Assumption Changes	$ 977	$ (267)
Net Actuarial (Gain)/Loss	1,397	595
Total Expense	$ 2,487	$ 1,659
Less Amounts Paid	(752)	(714)
Ending Liability Balance	**$ 20,882**	**$ 19,147**

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for IBNR claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. For FYs 2024 and 2023, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues for the current and prior four years. Interest rate assumptions utilized for discounting as of September 30, 2024, and September 30, 2023, were:

	2024	2023
Wage Benefits	2.648% in Year 1 and years thereafter	2.326% in Year 1 and years thereafter
Medical Benefits	2.399% in Year 1 and years thereafter	2.112% in Year 1 and years thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (i.e., cost of living adjustments [COLA]) and medical inflation factors (i.e., consumer price index-medical [CPI-M]) are applied to the calculations of projected future benefits. The actual rates for these factors are also used to adjust the methodology's historical payments to current year constant dollars. The compensation COLAs and CPI-Ms used in the projections are:

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
COLA	N/A	4.27%	4.42%	4.17%	3.17%	2.57%	2.39%	2.30%	2.30%	2.30%	2.30%
CPI-M	N/A	2.55%	2.85%	3.21%	3.37%	3.98%	3.93%	3.93%	3.93%	3.93%	3.93%

Note 13. Accrued Liabilities (in Millions)

	2024	2023
Grant Liability	$ 4,297	$ 4,238
Other Accrued Liabilities	12,874	13,197
Total Accrued Liabilities	**$ 17,171**	**$ 17,435**

Note 14. Other Liabilities (in Millions)

	2024	2023
Intragovernmental		
Legal Liabilities	$ 1,219	$ 1,218
Benefit Program Contribution Payable	150	125
Custodial Liabilities	261	139
Other	6	88
Total Intragovernmental	**$ 1,636**	**$ 1,570**
Other than Intragovernmental		
Custodial Liabilities	$ 16	$ 22
Lease Liability	789	-
Other	3,826	603
Total Other than Intragovernmental	**$ 4,631**	**$ 625**

The increase in Other Liabilities consists primarily of accrued payments of $3.2 billion for the Medicare Shared Savings Program ACO in Other for Other than Intragovernmental Liabilities. Legal liabilities of $1.2 billion ($1.2 billion as of September 30, 2023) consists of reimbursable claims due to the Judgment Fund, which is administered by Fiscal Service.

In FY 2024, HHS applied the provisions of SFFAS 54. The Lease Liability represents lessee funded and unfunded lease liability for right-to-use lease assets. The net present value of future payments over the term of the lease is recognized and amortized over the term of the arrangements.

Note 15. Contingencies and Commitments

HHS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the federal government. HHS has accrued contingent liabilities where a loss is determined to be probable, and the amount can be estimated. The liabilities are primarily related to the Medicaid audit and program disallowances. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined. Selected contingencies and commitments are described below.

Medicaid Audit and Program Disallowances and Legal Contingencies

The amount of $5.3 billion as of September 30, 2024 ($18.6 billion as of September 30, 2023) consists of $4.3 billion for Medicaid audit and program disallowances, reimbursement of state plan amendments and $1.0 billion for legal contingencies. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or HHS can decrease the state's authority. HHS will be required to pay these amounts if the appeals are decided in favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in *Salazar v Ramah Navajo Chapter*, dated June 18, 2012, and subsequent cases related to contract support costs have resulted in increased claims against IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years. The estimated amount recorded for contract support costs is $6.7 billion as of September 30, 2024 ($6.4 billion as of September 30, 2023).

Other contingent liabilities against HHS have been accrued in the financial statements for ASPR, the Vaccine Injury Compensation Program, and the Health Center Program malpractice claims through the *Federal Tort Claims Act*.

Note 16. Net Adjustments to Unobligated Balance, Brought Forward, October 1 (in Millions)

	2024	2023
Unobligated Balance, End of Year (from Prior Year)	$ 365,716	$ 282,986
Adjustments to Unobligated Balance Brought Forward:		
Recoveries of Prior Year Unpaid Obligations	60,160	68,111
Recoveries of Prior Year Paid Obligations	26,401	28,442
Appropriation Withdrawn	(7,032)	(6,866)
Appropriation Temporarily Precluded from Obligation - Prior Year	(8)	(2,530)
Cancelled Authority	(41,419)	(12,982)
Prior Year Adjustments	(181)	5
Other	369	491
Total Unobligated Balance Brought Forward, October 1	**$ 404,006**	**$ 357,657**

Net adjustments to Unobligated Balance, Brought Forward, October 1 primarily includes activity related to recoveries of prior year unpaid and paid obligations, appropriation withdrawn, appropriations which were temporarily precluded from obligation in the prior year, cancelled authority, and prior year adjustments.

HHS had $7.0 billion ($6.9 billion as of September 30, 2023) in Appropriation Withdrawn, which represents the return of prior year indefinite authority related to Medicaid premium matching for repayment of repayable advance.

Cancelled Authority increased by $28.4 billion primarily due to the return of the cancelled year authority to Treasury, which included $26.1 billion for PTF and $2.5 billion for CHIP.

Note 17. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances on the Combined Statement of Budgetary Resources consist of trust funds, appropriated funds, revolving funds, management funds, gift funds, cooperative research and development agreement funds, and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Combined Statement of Budgetary Resources; therefore, it is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and become available for obligation, as needed. The entire trust fund balances in the amount of $294.4 billion, as of September 30, 2024 ($236.4 billion as of September 30, 2023) are included in Investments on the Consolidated Balance Sheets.

Note 18. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

	2023			
	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 2,841,403	$ 2,475,687	$ 659,662	$ 2,368,288
Expired Accounts	(201,258)	-	-	-
Other	-	(7)	172	(6)
Budget of the U.S. Government	**$ 2,640,145**	**$ 2,475,680**	**$ 659,834**	**$ 2,368,282**

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2024, has not been published; therefore, no comparisons can be made between FY 2024 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2026 President's Budget* is expected to be released in February 2025 and may be obtained from OMB (unaudited) or from the Government Publishing Office (unaudited).

HHS reconciled the amounts of the FY 2023 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2023 from the Appendix in the *FY 2025 President's Budget* for budgetary resources, new obligations and upward adjustments, distributed offsetting receipts, and net outlays.

The *President's Budget* includes budgetary resources available for obligation. Budgetary resources that were not available are a reconciling item between the Combined Statement of Budgetary Resources and the *President's Budget*. The Expired Accounts line in the above table includes expired authority, recoveries, and other amounts included in the Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

Note 19. Undelivered Orders (in Millions)

	2024			2023		
	Federal	Non-Federal	Total	Federal	Non-Federal	Total
Undelivered Orders, Paid	$ 1,942	$ 1,574	$ 3,516	$ 2,406	$ 45,953	$ 48,359
Undelivered Orders, Unpaid	12,227	248,813	261,040	16,349	240,246	256,595
Total Undelivered Orders	**$ 14,169**	**$ 250,387**	**$ 264,556**	**$ 18,755**	**$ 286,199**	**$ 304,954**

Undelivered Orders include obligations that have been prepaid or advanced but not yet received, as well as goods and services ordered that have not been received. HHS reported $264.6 billion of budgetary resources obligated for undelivered orders as of September 30, 2024 ($305.0 billion as of September 30, 2023). The Undelivered Orders, Paid decrease of $44.8 billion is primarily due to Medicare Advantage and Prescription Drug benefit payments for October 2023 that occurred on September 29.

Note 20. Funds from Dedicated Collections (in Millions)

Medicare is the largest dedicated collections program managed by HHS and is presented in a separate column in the table. The Medicare program includes the HI Trust Fund; the SMI Trust Fund, which includes both Part B medical insurance, and the Medicare Prescription Drug Benefit – Part D; and the Medicare and Medicaid Integrity Programs. Other significant funds from dedicated collections programs include the Vaccine Injury Compensation Trust Fund, the Risk Adjustment Program, Program Management, and the Quality Improvement Organizations program.

Notes to the Principal Financial Statements

Balance Sheet	2024 Medicare	Other	Combined Funds from Dedicated Collections	Eliminations	Consolidated Funds from Dedicated Collections
Fund Balance with Treasury	$ 267,906	$ 19,939	$ 287,845	$ -	$ 287,845
Investments, Net	401,956	3,965	405,921	-	405,921
Accounts Receivable, Net	100,435	6,237	106,672	(106,019)	653
Advances and Prepayments	1	72	73	(66)	7
Other Assets	-	-	-	66	66
Total Intragovernmental Assets	**770,298**	**30,213**	**800,511**	**(106,019)**	**694,492**
Accounts Receivable, Net	23,120	7,899	31,019	-	31,019
Property, Plant and Equipment, Net	311	1,382	1,693	-	1,693
Advances and Prepayments	1	-	1	-	1
Other Assets	-	9	9	-	9
Total Other than Intragovernmental Assets	**23,432**	**9,290**	**32,722**	**-**	**32,722**
Total Assets	**$ 793,730**	**$ 39,503**	**$ 833,233**	**$ (106,019)**	**$ 727,214**
Accounts Payable	$ 110,009	$ 47	$ 110,056	$ (106,104)	$ 3,952
Debt	604	1	605	-	605
Other Liabilities	-	18	18	85	103
Total Intragovernmental Liabilities	**110,613**	**66**	**110,679**	**(106,019)**	**4,660**
Accounts Payable	163	253	416	-	416
Entitlement Benefits Due and Payable	88,832	-	88,832	-	88,832
Federal Employee Salary, Leave & Benefits Payable	10	144	154	-	154
Pension, Post-Employment, & Veterans Benefits Payable	-	13	13	-	13
Advances from Others and Deferred Revenue	2,621	1,368	3,989	-	3,989
Other Liabilities	4,277	12,908	17,185	-	17,185
Total Other than Intragovernmental Liabilities	**95,903**	**14,686**	**110,589**	**-**	**110,589**
Total Liabilities	**$ 206,516**	**$ 14,752**	**$ 221,268**	**$ (106,019)**	**$ 115,249**
Unexpended Appropriations	260,565	3,351	263,916	-	263,916
Cumulative Results of Operations	326,649	21,400	348,049	-	348,049
Total Liabilities and Net Position	**$ 793,730**	**$ 39,503**	**$ 833,233**	**$ (106,019)**	**$ 727,214**
Statement of Net Cost					
Gross Program Costs	$ 1,035,553	$ 23,927	$ 1,059,480	$ 114	$ 1,059,594
Less: Earned Revenues	(148,696)	(18,588)	(167,284)	(132)	(167,416)
Net Cost of Operations	**$ 886,857**	**$ 5,339**	**$ 892,196**	**$ (18)**	**$ 892,178**
Statement of Changes in Net Position					
Unexpended Appropriations:					
Beginning Balance	$ 271,601	$ 3,706	$ 275,307	$ -	$ 275,307
Appropriations Received	579,500	70	579,570	-	579,570
Appropriation Used	(514,432)	(419)	(514,851)	-	(514,851)
Other	(76,104)	(6)	(76,110)	-	(76,110)
Total Unexpended Appropriations	**260,565**	**3,351**	**263,916**	**-**	**263,916**
Cumulative Results of Operations:					
Beginning Balance	303,812	21,230	325,042	-	325,042
Appropriations Used	514,432	419	514,851	-	514,851
Other than Intragovernmental Nonexchange Revenue:					
Nonexchange Revenue – Other	342	4	346	-	346
Intragovernmental Nonexchange Revenue	405,319	1	405,320	-	405,320
Donations and Forfeitures of Cash and Cash Equivalents	-	85	85	-	85
Transfers in/out without Reimbursement	(10,407)	4,884	(5,523)	-	(5,523)
Imputed Financing	8	116	124	(18)	106
Other	-	-	-	-	-
Net Cost of Operations	886,857	5,339	892,196	(18)	892,178
Net Change and Cumulative Results of Operations	22,837	170	23,007	-	23,007
Total Cumulative Results of Operations	**326,649**	**21,400**	**348,049**	**-**	**348,049**
Net Position, End of Period	**$ 587,214**	**$ 24,751**	**$ 611,965**	**$**	**$ 611,965**

Balance Sheet	2023 Medicare	Other	Combined Funds from Dedicated Collections	Eliminations	Consolidated Funds from Dedicated Collections
Fund Balance with Treasury	$ 280,536	$ 20,305	$ 300,841	$ -	$ 300,841
Investments, Net	355,929	3,967	359,896	-	359,896
Accounts Receivable, Net	118,273	6,468	124,741	(124,107)	634
Advances and Prepayments	-	104	104	(98)	6
Other Assets	-	-	-	98	98
Total Intragovernmental Assets	**754,738**	**30,844**	**785,582**	**(124,107)**	**661,475**
Accounts Receivable, Net	24,555	7,297	31,852	-	31,852
Property, Plant and Equipment, Net	432	1,750	2,182	-	2,182
Advances and Prepayments	45,119	-	45,119	-	45,119
Other Assets	-	8	8	-	8
Total Other than Intragovernmental Assets	**70,106**	**9,055**	**79,161**	**-**	**79,161**
Total Assets	**$ 824,844**	**$ 39,899**	**$ 864,743**	**$ (124,107)**	**$ 740,636**
Accounts Payable	$ 127,916	$ 53	$ 127,969	$ (124,201)	$ 3,768
Debt	2,854	-	2,854	-	2,854
Other Liabilities	-	13	13	94	107
Total Intragovernmental Liabilities	**130,770**	**66**	**130,836**	**(124,107)**	**6,729**
Accounts Payable	173	312	485	-	485
Entitlement Benefits Due and Payable	106,220	-	106,220	-	106,220
Federal Employee Salary, Leave & Benefits Payable	9	117	126	-	126
Pension, Post-Employment, & Veterans Benefits Payable	-	13	13	-	13
Advances from Others and Deferred Revenue	1,859	1,231	3,090	-	3,090
Other Liabilities	10,400	13,224	23,624	-	23,624
Total Other than Intragovernmental Liabilities	**118,661**	**14,897**	**133,558**	**-**	**133,558**
Total Liabilities	**$ 249,431**	**$ 14,963**	**$ 264,394**	**$ (124,107)**	**$ 140,287**
Unexpended Appropriations	271,601	3,706	275,307	-	275,307
Cumulative Results of Operations	303,812	21,230	325,042	-	325,042
Total Liabilities and Net Position	**$ 824,844**	**$ 39,899**	**$ 864,743**	**$ (124,107)**	**$ 740,636**
Statement of Net Cost					
Gross Program Costs	$ 1,006,024	$ 22,375	$ 1,028,399	$ (40)	$ 1,028,359
Less: Earned Revenues	(141,694)	(16,932)	(158,626)	24	(158,602)
Net Cost of Operations	**$ 864,330**	**$ 5,443**	**$ 869,773**	**$ (16)**	**$ 869,757**
Statement of Changes in Net Position					
Unexpended Appropriations:					
Beginning Balance	$ 174,874	$ 3,830	$ 178,704	$ -	$ 178,704
Appropriations Received	593,419	124	593,543	-	593,543
Other Adjustments	(19,035)	(11)	(19,046)	-	(19,046)
Appropriation Used	(477,657)	(237)	(477,894)	-	(477,894)
Total Unexpended Appropriations	**271,601**	**3,706**	**275,307**	**-**	**275,307**
Cumulative Results of Operations:					
Beginning Balance	324,469	21,730	346,199	-	346,199
Appropriations Used	477,657	237	477,894	-	477,894
Other than Intragovernmental Nonexchange Revenue:					
Nonexchange Revenue – Other	436	10	446	-	446
Intragovernmental Nonexchange Revenue	375,176	1	375,177	-	375,177
Donations and Forfeitures of Cash and Cash Equivalents	-	64	64	-	64
Transfers in/out without Reimbursement	(9,602)	4,584	(5,018)	-	(5,018)
Imputed Financing	6	74	80	(16)	64
Other	-	(27)	(27)	-	(27)
Net Cost of Operations	864,330	5,443	869,773	(16)	869,757
Net Change and Cumulative Results of Operations	(20,657)	(500)	(21,157)	-	(21,157)
Total Cumulative Results of Operations	**303,812**	**21,230**	**325,042**	**-**	**325,042**
Net Position, End of Period	**$ 575,413**	**$ 24,936**	**$ 600,349**	**$**	**$ 600,349**

Note 21. Stewardship Land

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.8 million American Indians and Alaska Natives, who are members of 574 federally recognized tribes in 37 states. Comprehensive primary healthcare and disease prevention services are provided through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. These facilities are predominately primary care settings and are managed by IHS, tribal, and urban Indian health programs. Health services are provided on tribal/reservation trust land that DOI assigned to IHS for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

The table below presents stewardship land held by HHS:

Indian Trust Land by Locations and Number of Sites

IHS Area	2024	2023
Albuquerque	6	6
Bemidji	2	2
Billings	7	7
Great Plains	9	9
Navajo	36	36
Oklahoma City	1	1
Phoenix	10	10
Portland	3	3
Tucson	5	5
Total	**79**	**79**

Note 22. Reconciliation of Net Cost to Net Outlays (in Millions)

The Reconciliation of Net Cost of Operations to Net Outlays reconciles proprietary basis of accounting Net Cost of Operations to budgetary basis of accounting Outlays, Net. Reconciling items include activity impacting Net Cost of Operations but are not included in Outlays, Net and activity impacting Outlays, Net but are not included in Net Cost of Operations. The miscellaneous items account for activities to be added or removed based on HHS activities that are not reflected in the reconciliation crosswalk.

Notes to the Principal Financial Statements

	2024			2023		
	Intragovernmental	Other than Intragovernmental	Total	Intragovernmental	Other than Intragovernmental	Total
Net Cost of Operations	**$ 12,063**	**$ 1,727,256**	**$ 1,739,319**	**$ 24,565**	**$ 1,690,378**	**$ 1,714,943**
Components of Net Cost Not Part of the Outlays:						
Property, Plant, and Equipment Depreciation Expense	-	(1,194)	(1,194)	-	(1,349)	(1,349)
Lessee Lease Amortization	-	(52)	(52)	-	-	-
Cost of Goods Sold	-	(25)	(25)	-	(28)	(28)
Applied Overhead/Cost Capitalization Offset	-	531	531	-	7,741	7,741
Gains/Losses on All Other Investments	-	(2,105)	(2,105)	-	239	239
	-	**(2,845)**	**(2,845)**	**-**	**6,603**	**6,603**
Increase/(Decrease) in Assets:						
Accounts Receivable	(3)	(801)	(804)	(45)	(938)	(983)
Securities and Investments	553	-	553	107	-	107
Advances and Prepayments	278	(45,131)	(44,853)	140	5,989	6,129
Other Assets	-	(91)	(91)	-	21	21
	828	**(46,023)**	**(45,195)**	**202**	**5,072**	**5,274**
(Increase)/Decrease in Liabilities:						
Accounts Payable	37	170	207	730	(75)	655
Lease Liability		(789)	(789)	-	-	-
Debt	(69)	-	(69)	4,984	-	4,984
Benefits Due and Payable	-	17,946	17,946	-	(18,366)	(18,366)
Federal Employee Salary, Leave, and Benefits Payable	-	(233)	(233)	-	61	61
Pensions and Other Post-Employment Benefits Payable	-	(1,741)	(1,741)	-	(944)	(944)
Accrued Liabilities	-	264	264	-	(1,178)	(1,178)
Contingencies and Commitments	-	12,501	12,501	-	(11,712)	(11,712)
Environmental and Disposal Liabilities	-	(69)	(69)	-	(71)	(71)
Other Liabilities	(100)	(4,190)	(4,290)	15	(1,238)	(1,223)
	(132)	**23,859**	**23,727**	**5,729**	**(33,523)**	**(27,794)**
Other Financing Sources:						
Imputed Financing	(1,047)	-	(1,047)	(797)	-	(797)
Total Components of Net Cost Not Part of the Outlays	**(351)**	**(25,009)**	**(25,360)**	**5,134**	**(21,848)**	**(16,714)**
Components of Outlays Not Part of Net Cost:						
Acquisition of Capital Assets	$ 26	1,251	1,277	$ 13	7,349	7,362
Acquisition of Inventory	-	2,432	2,432	-	8,755	8,755
Other Financing Sources:						
Donated Revenue	-	(85)	(85)	-	(64)	(64)
Transfers (in)/out without Reimbursement	1,411	-	1,411	531	-	531
Total Components of Outlays Not Part of Net Cost	**1,437**	**3,598**	**5,035**	**544**	**16,040**	**16,584**
Miscellaneous Items:						
Custodial/Non-Exchange Revenue	(11,359)	386	(10,973)	(10,113)	674	(9,439)
Non-entity activity	1,525	-	1,525	865	-	865
Other Temporary Timing Differences	-	(6,267)	(6,267)	-	-	-
Appropriated Receipts for Trust/Special Funds	-	11,323	11,323	-	9,418	9,418
Reconciling Items:						
Debt	69	-	69	(4,984)	-	(4,984)
Custodial/Non-Exchange Revenue	11,359	(386)	10,973	10,113	(674)	9,439
Miscellaneous Receipts	(750)	-	(750)	-	(477)	(477)
Investment Interest Receivable	(553)	-	(553)	(128)	-	(128)
Federal Share of Child Support Collections	(450)	-	(450)	(541)	-	(541)
Inventory Adjustment	-	6,267	6,267	-	(6,813)	(6,813)
Other Expenses Not Requiring Budgetary Resources	-	(11,380)	(11,380)	-	(5,966)	(5,966)
Unfunded Lease Liability	-	764	764	-	-	-
Return of Nonrecurring Expenses Fund and COVID-19 Rescinded Funds	-	-	-	1,981	-	1,981
Total Miscellaneous Items	**(159)**	**707**	**548**	**(2,807)**	**(3,838)**	**(6,645)**
Net Outlays	**$ 12,990**	**$ 1,706,552**	**$ 1,719,542**	**$ 27,436**	**$ 1,680,732**	**$ 1,708,168**
Other Reconciling Items			1,457			458
Agency Outlays, Net			**$ 1,720,999**			**$ 1,708,626**

Note 23. Combined Schedule of Spending (in Millions)

The Combined Schedule of Spending presents an overview of how departments or agencies spend (i.e., obligate) money. The data used to populate this schedule are the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Combined Statement of Budgetary Resources.

Additional efforts to improve the transparency of spending activity in the federal government have come to fruition with the implementation of the *Digital Accountability and Transparency Act of 2014* (DATA Act). This legislation makes available to the public, at no cost, a searchable website that provides award and financial information on contracts and financial assistance awards (including grants). While the underlying obligation data used to generate both the Combined Schedule of Spending and the DATA Act submission are the same, there is a fundamentally different purpose behind each, which should be considered when comparing the two. The Combined Schedule of Spending presents total budgetary resources, total new obligations, and upward adjustments for the reporting entity. The website displaying the DATA Act submission, USAspending.gov (unaudited), collects the same data, as well as recoveries. Additional differences include the definition of key attributes in each. Programs for the Combined Schedule of Spending are defined by the Treasury Account Symbol, whereas the DATA Act uses the Program and Financing lines from the *President's Budget* (unaudited). The Combined Schedule of Spending and DATA Act both report spending activity by object class. However, the DATA Act requires granular-level object class assignments, while the Combined Schedule of Spending groups object classes at a higher level for presentation purposes. Additionally, the DATA Act submission at the award-level data does not include certain obligations, such as personnel compensation, travel, utilities, leases, intra-departmental and interagency spending, and various other categories of financial awards. The Combined Schedule of Spending has no such exclusions and is similar to the program activity reporting file for DATA Act. Lastly, the DATA Act reporting responsibility for award-level activity in allocation accounts is always assigned to the child entity. This is not entirely consistent with allocation account reporting for the financial statements for which either the parent or child will report.

What Money is Available to Spend? This section presents resources that were available to spend, as reported in the Combined Statement of Budgetary Resources. Total Resources refers to Total Budgetary Resources as described in the Combined Statement of Budgetary Resources and represents amounts approved for spending by law. Amount Available but Not Agreed to be Spent represents amounts that HHS was allowed to spend but did not take action to spend by the end of the fiscal year. Amount Not Available to be Spent represents amounts that HHS was not approved to spend during the current fiscal year. Total Amounts Agreed to be Spent represents spending actions taken by HHS – including contracts, purchase orders, grants, or other legally binding agreements of the federal government – to pay for goods or services. This line total agrees to the New Obligations and Upward Adjustments line in the Combined Statement of Budgetary Resources.

Who did the Money Go To? This section identifies the recipient of the money by federal and non-federal entities. Amounts in this section reflect amounts agreed to be spent and agree to the New Obligations and Upward Adjustments line on the Statement of Budgetary Resources.

How was the Money Spent/Issued? This section presents services or items that were purchased and categorized by program with spending greater than $3.0 billion. Grants, Subsidies, & Contributions, Insurance Claims and Indemnities, Other Contractual Services and Personnel Compensation & Benefits are the object classes that have a material impact on HHS reporting. HHS Medicare payments are reported under Insurance Claims and Indemnities based on the OMB Circular A-11, *Preparation, Submission, and Execution of the Budget*, object class definition.

Combined Schedule of Spending

For the Years Ended September 30, 2024 and 2023
(in Millions)

What Money is Available to Spend		2024		2023
Total Resources	$	2,864,571	$	2,841,403
Less Amount Available but Not Agreed to be Spent		63,063		145,708
Less Amount Not Available to be Spent		282,763		220,008
Total Amounts Agreed to be Spent	**$**	**2,518,745**	**$**	**2,475,687**

Who Did the Money Go To		2024		2023
Federal	$	15,063	$	15,918
Non-Federal		2,503,682		2,459,769
Total Amounts Agreed to be Spent	**$**	**2,518,745**	**$**	**2,475,687**

Total Amounts Agreed to be Spent increased by $43.1 billion, mostly due to increases in Payments to the Healthcare Trust Funds, Medicaid, SMI and Part D. This is offset by decreases in HI and COVID-19 funding for the *American Rescue Plan Act of 2021* as well as the *Defense Production Act*.

Combined Schedule of Spending by Object Class

For the Year Ended September 30, 2024

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 682,332	$ -	$ 4	$ -	$ -	$ 682,336
Federal Supplementary Medical Insurance Trust Fund	-	519,881	126	1	6,031	526,039
Payments to Trust Funds	383,602	-	-	-	119,286	502,888
Federal Hospital Insurance Trust Fund	-	385,080	22	-	3,732	388,834
Medicare Prescription Drug Account	-	120,620	-	-	512	121,132
Taxation on OASDI Benefits, HI	39,794	-	-	-	-	39,794
State Children's Health Insurance Fund	20,669	-	9	-	-	20,678
Temporary Assistance for Needy Families	16,611	-	89	18	2	16,720
Children and Families Services Programs	14,528	1	363	199	22	15,113
Risk Adjustment Program Payments	-	10,408	-	-	45	10,453
Payments for Foster Care and Permanency	10,027	-	62	1	1	10,091
Payment to States for the Child Care and Development Block Grant*	8,563	-	237	23	2	8,825
Refugee and Entrant Assistance	7,023	-	1,469	122	10	8,624
Indian Health Services	3,250	1	1,848	1,943	1,506	8,548
National Cancer Institute	4,441	-	2,111	783	113	7,448
Public Health and Social Services Emergency Fund	1,143	-	3,664	78	2,544	7,429
CMS Program Management	124	-	6,170	864	269	7,427
Vaccines for Children Program	145	-	147	35	6,911	7,238
FDA Salaries and Expenses	298	1	2,348	3,769	508	6,924
National Institute of Allergy and Infectious Diseases	4,033	-	2,117	477	103	6,730
Primary Health Care	5,570	-	152	119	185	6,026
Payments to States for Child Support Enforcement and Family Support Programs	4,642	-	485	-	-	5,127
National Institute on Aging	3,959	-	442	146	53	4,600
Substance Abuse Treatment	4,007	-	127	34	14	4,182
Low Income Home Energy Assistance	4,128	-	12	2	1	4,143
National Heart, Lung, and Blood Institute	3,179	-	615	221	34	4,049
Child Care Entitlement to States*	3,573	-	51	-	-	3,624
National Institute of General Medical Sciences	3,123	-	68	44	44	3,279
Other Agency Budgetary Accounts	41,658	798	22,528	8,753	6,707	80,444
Total Amounts Agreed to be Spent	**$ 1,270,422**	**$ 1,036,790**	**$ 45,266**	**$ 17,632**	**$ 148,635**	**$ 2,518,745**

*Funding from the Child Care and Development Fund

Combined Schedule of Spending by Object Class

For the Year Ended September 30, 2023

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 660,165	$ 1	$ -	$ -	$ -	$ 660,166
Federal Supplementary Medical Insurance Trust Fund	-	503,687	179	1	7,493	511,360
Payments to the Healthcare Trust Funds	355,195	-	-	-	114,817	470,012
Federal Hospital Insurance Trust Fund	-	415,736	10	-	5,677	421,423
Medicare Prescription Drug Account	-	113,632	-	1	73	113,706
Taxation on OASDI Benefits, HI	34,968	-	-	-	-	34,968
Public Health and Social Services Emergency Fund	6,825	-	9,078	378	2,802	19,083
State Children's Health Insurance Fund	18,992	-	3	-	-	18,995
Temporary Assistance for Needy Families	16,702	-	93	16	1	16,812
Children and Families Services Programs	14,045	1	364	175	16	14,601
Refugee and Entrant Assistance	8,607	1	2,849	84	16	11,557
Payments for Foster Care and Permanency	10,145	-	52	1	-	10,198
Risk Adjustment Program Payments	-	9,245	-	-	-	9,245
Payment to States for the Child Care and Development Block Grant*	7,777	-	255	17	1	8,050
Indian Health Services	3,295	1	1,564	1,809	1,250	7,919
National Cancer Institute	4,454	-	2,002	741	154	7,351
CMS Program Management	119	-	6,079	820	200	7,218
National Institute of Allergy and Infectious Diseases	4,088	-	2,181	448	146	6,863
FDA Salaries and Expenses	318	1	2,477	3,466	588	6,850
Low Income Home Energy Assistance	6,110	-	8	1	-	6,119
Primary Health Care	5,399	-	306	106	8	5,819
Vaccines for Children Program	139	-	90	27	4,960	5,216
Payments to States for Child Support Enforcement and Family Support Programs	4,320	-	571	-	-	4,891
National Institute on Aging	3,927	-	409	125	40	4,501
Substance Abuse Treatment	4,026	-	107	48	-	4,181
National Heart, Lung, and Blood Institute	3,210	-	625	205	35	4,075
Child Care Entitlement to States*	3,634	-	52	-	-	3,686
National Institute of General Medical Sciences	3,127	-	107	41	-	3,275
Mental Health	2,889	-	198	32	2	3,121
National Institute of Neurological Disorders and Stroke	2,280	-	385	143	46	2,854
NIH Office of the Director	1,868	-	702	235	19	2,824
CDC-Wide Activities and Program Support	1,258	-	1,274	229	54	2,815
NIH Service and Supply Fund	-	-	1,913	387	421	2,721
Aging and Disability Services Programs	2,546	-	75	37	4	2,662
Ryan White HIV/AIDS Program	2,406	-	116	43	4	2,569
Health Care Fraud and Abuse Control Program	-	-	1,586	107	789	2,482
National Institute of Diabetes and Digestive and Kidney Diseases	1,993	-	284	157	24	2,458
National Institute of Mental Health	1,821	-	332	138	16	2,307
Defense Production Act Medical Supplies Enhancement	1,216	-	220	2	714	2,152
Other Agency Budgetary Accounts	25,664	765	12,286	6,720	3,147	48,582
Total Amounts Agreed to be Spent	**$ 1,223,528**	**$ 1,043,070**	**$ 48,832**	**$ 16,740**	**$ 143,517**	**$ 2,475,687**

*Funding from the Child Care and Development Fund

Note 24. Reclassification of Financial Statement Line Items for Financial Report Compilation Process

Reclassification of Statement of Net Cost to Line Items Used for Government wide Statement of Net Cost For the Year Ended September 30, 2024 (in Millions)						
FY 2024 HHS Statement of Net Cost		Line Items Used to Prepare FY 2024 Government-wide Statement of Net Cost				
Financial Statement Line	Amounts	Dedicated Collections Combined	Dedicated Collections Eliminations	All Other Amounts (with Eliminations)	Total	Reclassified Financial Statement Line
		$ 1,057,256	**$ -**	**$ 839,097**	**$ 1,896,353**	***Non-Federal Costs***
						Intragovernmental Costs
		514	-	2,273	2,787	*Benefit Program Costs*
		124	(18)	941	1,047	*Imputed Costs*
		1,428	132	6,554	8,114	*Buy/Sell Costs*
		-	-	23	23	*Purchase of Assets*
		-	-	11	11	*Borrowing and Other Interest Expense*
		158	-	675	833	*Other Expenses (w/o Reciprocals)*
		$ 2,224	**$ 114**	**$ 10,476**	**$ 12,814**	**Total Intragovernmental Costs**
CMS: Gross Cost	$ 1,684,513					
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	224,632					
Total Gross Costs	**$ 1,909,145**	**$ 1,059,480**	**$ 114**	**$ 849,572**	**$ 1,909,166**	***Total Reclassified Gross Costs***
		$ (167,381)	**$ -**	**$ (2,698)**	**$ (170,079)**	**Non-Federal Earned Revenue**
						Intragovernmental Earned Revenue
		97	(132)	(692)	(727)	*Buy/Sell Revenue*
		-	-	(23)	(23)	*Purchase of Assets Offset*
		$ 97	**$ (132)**	**$ (715)**	**$ (750)**	**Total Intragovernmental Earned Revenue**
CMS: Earned Revenue	$ (163,913)					
Other Segments: Earned Revenue	(6,890)					
Total Earned Revenue	**$ (170,803)**	**$ (167,284)**	**$ (132)**	**$ (3,414)**	**$ (170,830)**	***Total Reclassified Earned Revenue***
Actuarial (Gains) and Losses Commissioned Corps Retirement and Medical Plan Assumption Changes	977	-	-	977	977	Gain/Loss on Changes in Actuarial Assumptions (Non-Federal)
Net Cost of Operations	**$ 1,739,319**	**$ 892,196**	**$ (18)**	**$ 847,136**	**$ 1,739,314**	**Net Cost of Operations**

*Subtotals and totals may not equal due to rounding.

Reclassification of Statement of Changes in Net Position to Line Items Used for Government wide Statement of Operations and Changes in Net Position For the Year Ending September 30, 2024 (in Millions)			
FY 2024 HHS Statement of Change in Net Position		Line Items Used to Prepare FY 2024 Government-wide Statement of Changes in Net Position	
Financial Statement Line	Amounts	Total	Reclassified Financial Statement Line
UNEXPENDED APPROPRIATIONS			
Unexpended Appropriations, Beginning Balance	$ 601,521	$ 601,521	Unexpended Appropriations, Beginning Balance
Appropriations Received	1,497,092	1,497,092	Appropriations Received (RC 41)
Appropriations Transferred In/Out	(1,435)	4	Appropriations Transferred In/Out
Appropriations Used	(1,351,536)	(1,351,536)	Appropriations Used (RC 39)
Other Adjustments	(161,731)	(161,731)	Other Adjustments
Total Unexpended Appropriations	**$ 583,911**	**$ 585,350**	**Total Unexpended Appropriations**
CUMULATIVE RESULTS OF OPERATIONS			
Cumulative Results, Beginning Balance	$ 340,968	$ 340,967	Cumulative Results, Beginning Balance
Correction of Errors	231	231	Correction of Errors
Appropriations Used	1,351,536	1,351,536	Appropriations Expended (RC 38)
Nonexchange Revenue – Tax Revenue	391,904	391,904	Other Taxes and Receipts (RC 45)
Nonexchange Revenue – Investment Revenue	11,811	11,811	Federal Securities Interest Revenue, including Associated Gains/Losses (Non-Exchange) (RC 03)
		1,186	*Collections Transferred into a TAS Other Than the General Fund of the U.S. Government (RC 15)*
		3,031	*Other Taxes and Receipts (RC 45)*
		(840)	*Other Taxes and Receipts*
Nonexchange Revenue – Other	3,377	3,376	Total Other Taxes and Receipts
Donations and Forfeitures of Cash and Cash Equivalents	85	85	Donations and Forfeitures of Cash and Cash Equivalents
		951	*Expenditure Transfers in of Financing Sources (RC 09)*
		(3,800)	*Expenditure Transfers out of Financing Sources (RC 09)*
Transfers in/out Without Reimbursement – Budgetary	(1,411)	(2,849)	Total Transfers in/out without reimbursement
Donations and Forfeitures of Property	5	4	Donations and Forfeitures of Property
Imputed Financing	1,047	1,047	Imputed Financing Sources (RC 25)
		(2,964)	*Non-Entity Collections transferred to the General Fund (RC 44)*
		(52)	*Accrual for Non-Entity Amounts to be Collected and Transferred to the General Fund (RC 48)*
		1,566	*Other*
Other	(1,447)	(1,450)	Total Other
Total Financing Sources	**1,757,138**	**1,755,696**	**Total Financing Sources**
Net Cost of Operations	**1,739,319**	**1,739,314**	**Net Cost of Operations**
Ending Balance – Cumulative Results of Operations	**$ 358,787**	**$ 357,349**	**Total Cumulative Results of Operations**
Total Net Position	**$ 942,698**	**$ 942,698**	**Total Net Position**

To prepare the Financial Report of the U.S. Government (FR), Treasury requires agencies to submit an adjusted trial balance, which is a listing of amounts by USSGL account that appears in the financial statements. Treasury uses the trial balance information reported in Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) to develop a Reclassified Balance Sheet, Reclassified Statement of Net Cost, and a Reclassified Statement of Changes in Net Position for each agency, which are accessed using GTAS. Treasury eliminates all intragovernmental balances from the reclassified statements and aggregates lines with the same title to develop the FR statements. This note shows the HHS financial statements and the HHS reclassified statements prior to elimination of intragovernmental balances and prior to aggregation of repeated FR line items. A copy of the 2023 FR can be found at Fiscal Service's website (unaudited) and the 2024 FR will be posted to the site as soon as it is released.

The Statement of Net Cost and Statement of Changes in Net Position have immaterial differences primarily due to the presentations between HHS's financial statements and the reclassified financial statements. There is a difference

of $5 million for the Statements of Net Cost and Statement of Changes in Net Position due to custodial activities. The remainder of the differences are due to rounding.

Note 25. Statement of Social Insurance (Unaudited)

The Statement of Social Insurance (SOSI) presents, for the 75-year projection period, the present values of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds for both the open group and closed group of participants. The open group consists of 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. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2024 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

With two exceptions, the projections are based on the current-law provisions[6] of the *Social Security Act* as of the date of release of the Medicare Trustees Report. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted. The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022 effective date; however, implementation was initially delayed until January 1, 2023. Since then, enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the *Inflation Reduction Act of 2022*. This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the *Inflation Reduction Act* is to reduce government expenditures for Part B, to increase expenditures for Part D from 2027 through 2030, and to decrease Part D

[6]Due to the timing and the limited effect on the financial outlook of the trust funds, the projections do not reflect the impact of the Medicare provisions in the *Consolidated Appropriations Act, 2024* (Public Law 118-42), which was enacted on March 9, 2024. The provisions included were temporary extensions of prior policies, the elimination of the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through November of 2032. The estimated impact is less than 0.05 percent of Medicare benefits over FYs 2024 through 2033, and there is no impact beyond 2033.

expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10-year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the *Inflation Reduction Act* will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the *Inflation Reduction Act*, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the *Inflation Reduction Act* are likely to result in price growth that is lower than overall health prices and closer to the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative provisions were enacted during the public health emergency that increased spending, and the use of telehealth was greatly expanded. More than offsetting these additional costs during the pandemic, spending for non-COVID-19 care declined significantly.

Now that the public health emergency has ended and Medicare fee-for-service per capita spending has stabilized, the Trustees place a greater reliance on recent experience when developing the cost projections. However, they continue to make three pandemic-related adjustments to the projections. The first is to account for the morbidity improvement in the surviving population, which is expected to continue to affect spending levels through 2029. The second adjustment accounts for the ending of the waiver regarding the 3-day inpatient stay requirement to receive skilled nursing facility services. The per capita spending projections typically include factors for price updates and changes in the utilization and mix of services. As a result of the expiration of this waiver, the Trustees have increased their inpatient spending growth factor by 1.9 percentage points and decreased the skilled nursing facility spending growth factor by 7.5 percentage points in 2024. Finally, the third adjustment is to account for home health spending that was still, in 2023, significantly lower than estimated prior to the pandemic. As a result of the recent home health staffing shortages, the Trustees continue to consider the spending level for this service to be suppressed. Thus, they have increased their home health spending growth factor by 2.9 percentage points in each of the next 3 years (2024–2026).

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. They are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility

age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and healthcare cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the SOSI also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

The estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary healthcare costs, wages, and the CPI; fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year-to-year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary healthcare costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2024 SOSI actuarial projections are drawn from the Medicare Trustees Reports for 2024. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website (unaudited).[7]

[7]The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation and is likewise not subject to audit by independent auditors.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2024

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real interest rate[12]
2024	1.67	1,809,000	784.1	0.99	3.78	2.76	1.7	2.2[9,10]	3.7[10,11]	9.3[11]	1.4
2030	1.83	1,349,000	735.3	1.89	4.33	2.40	2.0	5.0	6.0	1.6	1.7
2040	1.90	1,293,000	676.9	1.21	3.64	2.40	1.9	4.3	5.1	2.9	2.2
2050	1.90	1,260,000	624.6	1.09	3.51	2.40	1.9	3.4	3.8	4.1	2.3
2060	1.90	1,244,000	578.2	1.14	3.57	2.40	1.9	3.4	3.8	4.0	2.3
2070	1.90	1,230,000	537.2	1.14	3.57	2.40	1.8	3.4	3.5	3.8	2.3
2080	1.90	1,221,000	500.6	1.13	3.55	2.40	1.9	3.4	3.7	3.9	2.3
2090	1.90	1,216,000	468.1	1.13	3.56	2.40	2.0	3.5	3.7	3.9	2.3

[1]Average number of children per woman.
[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated total population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4]Annual percentage change in average wages adjusted for the average percentage change in the CPI.
[5]Average annual wage in covered employment.
[6]The CPI represents a measure of the average change in prices over time in a fixed group of goods and services.
[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9]Reflects policy change to exclude medical education expenses associated with Medicare Advantage (MA) enrollees from the fee-for-service per capita costs used in the development of MA spending, as described in Section IV.C of the 2024 Medicare Trustees Report.
[10]Reflects lower spending for hospital and home health agency services.
[11]Reflects *Inflation Reduction Act of 2022*.
[12]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the SOSI are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. Table 2 summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance FY 2024-2020

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real wage growth[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real interest rate[9]
2024	1.9	1,216,000	468.1	1.13	3.56	2.40	2.0	3.5	3.7	3.9	2.3
2023	2.0	1,216,000	469.9	1.12	3.55	2.40	2.1	3.5	3.7	4.0	2.3
2022	2.0	1,217,000	469.9	1.14	3.54	2.40	2.1	3.5	3.7	4.2	2.3
2021	2.0	1,218,000	472.7	1.14	3.54	2.40	2.1	3.4	3.7	4.2	2.3
2020	1.95	1,218,000	460.5	1.13	3.53	2.40	2.0	3.3	3.6	4.1	2.3

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2040.

[2]Includes lawful permanent resident (LPR) immigration, net of emigration, as well as other-than-LPR immigration. The ultimate level of net LPR immigration is 788,000 persons per year, and the assumption for annual net other-than-LPR varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated total population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

[4]Beginning with the 2023 Trustees Report, for consistency with other growth rate measures, the real-wage growth is defined as the annual percentage change in average wages adjusted for the average percentage change in the CPI. In the 2022 and earlier Trustees Reports it is presented as the difference between percentage increases in wages and the CPI and referred to as real-wage differential. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

[5]Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

[6] The CPI represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

Note 26. Alternative Statement of Social Insurance Projections (Unaudited)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

Certain features of current law may result in some challenges for the Medicare program. With the end of the COVID-19 public health emergency, uncertainty related to the effects of the pandemic on the economy, demographics, and healthcare delivery has been significantly reduced. Uncertainty remains, however, regarding adherence to current-law payment updates, particularly in the long range. This concern is more immediate for physician services, for which a negative payment rate update is projected for 2025 and updates are projected to be below the rate of inflation in all future years. Payment rate updates for most non-physician categories of Medicare

providers are reduced by the growth in economy-wide private nonfarm business total factor productivity[8] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in the Medicare Trustees Report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028–2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Finally, the scenario assumes the continuation of the bonuses for qualified physicians in advanced alternative payment models (advanced APMs), which are expected to end after 2025, and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2024.[9] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

Table 3 contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

[8]Beginning with the November 18, 2021 release of the productivity data, the Bureau of Labor Statistics replaced the term multifactor productivity with the term total factor productivity, a change in name only as the underlying methods and data were unchanged.

[9]The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the PPACA. The assumption regarding physician payments is being used because the enactment of MACRA in 2015 replaced the SGR with specified physician updates.

Table 3: Medicare Present Values

(in Billions)

	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income		
Part A	$ 32,502	$ 32,573
Part B	58,665	67,210
Part D	11,008	11,005
Expenditures		
Part A	35,120	41,547
Part B	58,665	67,210
Part D	11,008	11,005
Income less expenditures		
Part A	(2,618)	(8,974)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2024 Trustees Report.

[2]A set of illustrative alternative Medicare projections has been prepared under a hypothetical modification to current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly 40 percent of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-percent reduction in annual cost growth each year for these providers. If the payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans, the physician updates transitioned to the Medicare Economic Index, and the bonuses paid to qualified physicians in advanced APMs did not expire, as illustrated under the alternative scenario, the estimated present values of Part A would be higher than the current-law projections by roughly 18 percent and Part B expenditures would be higher than the current-law projections by roughly 15 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 15 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very small difference is the result of a slight change in the discount rates that are used to calculate the present values.

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

Note 27. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2023 to the period beginning on January 1, 2024, and the reconciliation from the period beginning on January 1, 2022 to the period beginning on January 1, 2023. The reconciliation identifies several significant components of the change and provides reasons for the change.

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

The five changes considered in the SCSIA are, in order, as follows:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and healthcare assumptions, and
- changes in law.

All estimates in the SCSIA represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect these assumptions have once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flows represents a positive change (improving financing), while a decrease in the present value of net cash flows represents a negative change (worsening financing).

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the SCSIA are for the current and prior years and are based on various economic and demographic assumptions used for the intermediate assumptions in the Medicare Trustees Reports for those years. Table 1 of Note 25 summarizes these assumptions for the current year.

Period beginning on January 1, 2023 and ending January 1, 2024

Present values as of January 1, 2023 are calculated using interest rates from the intermediate assumptions of the 2023 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2024. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2023 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and healthcare assumptions are calculated using the interest rates under the intermediate assumptions of the 2024 Trustees Report.

Period beginning on January 1, 2022 and ending January 1, 2023

Present values as of January 1, 2022 are calculated using interest rates from the intermediate assumptions of the 2022 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2023. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2022 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and healthcare assumptions are calculated using the interest rates under the intermediate assumptions of the 2023 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2023 to the period beginning on January 1, 2024

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2023-97) to the current valuation period (2024-98) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2023, replaces it with a much larger negative net cash flow for 2098, and measures the present values as of January 1, 2024, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2023-97 to 2024-98. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2023 are realized. The change in valuation period resulted in a small decrease in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $157 billion.

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2022-96) to the current valuation period (2023-97) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2022, replaces it with a much larger negative net cash flow for 2097, and measures the present values as of January 1, 2023, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2022-96 to 2023-97. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2022 are realized. The change in valuation period resulted in a slight decrease in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $126 billion.

Change in Projection Base

From the period beginning on January 1, 2023 to the period beginning on January 1, 2024

Actual income and expenditures in 2023 were different from what was anticipated when the 2023 Trustees Report projections were prepared. Part A income was higher and expenditures were lower than estimated based on actual experience. For Part B and Part D, income and expenditures were both higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $746 billion in the

present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2023 and January 1, 2024 is incorporated in the current valuation and is less than projected in the prior valuation.

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023

Actual income and expenditures in 2022 were different from what was anticipated when the 2022 Trustees Report projections were prepared. For Part A and Part B income and expenditures were lower than estimated based on actual experience. Part D total income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $1,238 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2022 and January 1, 2023 is incorporated in the current valuation and is less than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2023 to the period beginning on January 1, 2024

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

For the current valuation (beginning on January 1, 2024), there was one change to the ultimate demographic assumptions.

- The ultimate total fertility rate (TFR) was lowered from 2.0 children per woman to 1.9 children per woman, and at the same time, the year the ultimate TFR is reached was changed from 2056 to 2040.

In addition to this change to the ultimate demographic assumptions, the starting demographic values, and the way these values transition to the ultimate assumptions were changed. The most significant changes are identified below.

- Final birth rate data for calendar year 2022 and preliminary data for 2023 indicated slightly lower birth rates than were assumed in the prior valuation, leading to slightly lower assumed birth rates during the period of transition to the ultimate level.
- Updates to near-term mortality assumptions to better reflect the effects of the COVID-19 pandemic led to an increase in death rates through 2024 compared to the prior valuation.
- Mortality data, historical population data, other-than-lawful permanent resident (LPR) immigration data, and divorce data were updated since the prior valuation.

There was one notable change in demographic methodology. The method for projecting fertility rates during the transition period to the ultimate rate was modified to produce more reasonable paths to the ultimate assumed rates by age group than had been previously used.

These changes resulted in a decrease in the estimated future net cash flow. For Part A, the present value of estimated income is lower, and the present value of estimated expenditures is higher. The present values of estimated expenditures and income for both Part B and Part D are higher. Overall, these changes decreased the present value of the estimated future net cash flow by $698 billion.

From the period beginning on January 1, 2022 to the period beginning on January 1, 2023

The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2023) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Projected birth rates through 2055, during the period of transition to the ultimate level, were slightly lower than in the prior valuation.
- Updates to near-term mortality assumptions to better reflect the effects of the COVID-19 pandemic led to an increase in death rates through 2024 compared to the prior valuation.
- Historical population data, other-than-LPR immigration data, and marriage and divorce data were updated since the prior valuation.

There was one notable change in demographic methodology. The method for projecting the age distributions of LPR new arrival and adjustment-of-status immigrants was updated reflecting recent data showing a slightly older population at the time of attaining LPR status than had previously been estimated.

These changes resulted in a decrease in the estimated future net cash flow. For Part A the present values of estimated income are lower and the present values of estimated expenditures are higher. The present values of estimated expenditures and income for Part B are lower and are higher for Part D. Overall, these changes decreased the present value of the estimated future net cash flow by $315 billion.

Changes in Economic and Healthcare Assumptions

For the period beginning on January 1, 2023 to the period beginning on January 1, 2024

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate economic assumptions for the current valuation (beginning on January 1, 2024) are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most significant changes are identified below.

- An update to educational attainment data caused a change in labor force participation rates at ages 55 and older for men and 50 and older for women.
- Historical OASDI covered employment for 2021 was higher than assumed under the prior valuation. Specifically, covered employment for 2021 was significantly higher than previously estimated at the youngest and oldest working ages, and lower for men at early prime working ages.
- Economic growth through 2023 was higher than assumed under the prior valuation, which led to a higher assumed level of labor productivity over the projection period.

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

- Lower Part A projected spending growth due to (i) a policy change to exclude medical education expenses associated with Medicare Advantage (MA) enrollees from the fee-for-service per capita costs used in the

development of MA spending, as described in Section IV.C of the 2024 Medicare Trustees Report, and (ii) lower projected spending for hospital and home health agency services.
- Lower Part D growth mainly beyond the short-range period.

The net impact of these changes was an increase in the estimated future net cash flow for total Medicare. For Part A, these changes increased the present value of estimated future income and decreased the present value of expenditures. For Part B, these changes resulted in an increase in the present value of estimated expenditures (and income) and for Part D they resulted in a decrease in the present value of estimated expenditure (and income). Overall, these changes increased the present value of the estimated future net cash flow by $2,106 billion.

For the period beginning on January 1, 2022 to the period beginning on January 1, 2023

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2023), there was one change to the ultimate economic assumptions.

- The annual percentage change in the average OASDI covered wage, adjusted for inflation, is assumed to average 1.14 percentage points over the last 65 years of the 75-year projection period. This is 0.02 percentage point higher than the value assumed for the prior valuation.

In addition to this change to the ultimate economic assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most significant changes are identified below.

- The levels of GDP and labor productivity are assumed to be about 3.0 percent lower by 2026 and for all years thereafter relative to the prior valuation.
- The assumed real interest rates over the first 10 years of the projection period are generally higher than those assumed for the prior valuation.

There was one notable change in economic methodology. The method for estimating the level of OASDI taxable wages for historical years 2000-21 was improved by adopting a more consistent approach for estimating completed values across various types of wages.

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

- Lower projected spending growth because of the anticipated effects of negotiating drug prices and other price growth constraints, as specified in the *Inflation Reduction Act of 2022*, and updated expectations with regard to the pandemic recovery.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $283 billion.

Changes in Law

For the period beginning on January 1, 2023 to the period beginning on January 1, 2024

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions had a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

The *Further Continuing Appropriations and Other Extensions Act, 2024* (Public Law 118-22, enacted on November 16, 2023) included provisions that affect the HI and SMI programs.

- The funding amount of $180 million that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 117-328 in last year's report, is increased to $466,795,056. This fund is intended to be available for improvements to the original fee-for-service program under Parts A and B, and funding is provided from the HI and SMI trust funds in such proportions as deemed appropriate by the Secretary of Health and Human Services.
- The 1.00 floor on the geographic index for physician work (which increases the work component for physicians who practice in locations where labor costs are lower than the national average) is extended through January 20, 2024 (from January 1, 2024).
- For clinical diagnostic laboratory tests that are not categorized as advanced diagnostic laboratory tests, changes are made to the market-based system used to update the Medicare clinical laboratory fee schedule. First, laboratories are exempted for another year from the requirement that they report private payer rates; the next data-reporting period is now the first quarter of 2025 (instead of the first quarter of 2024). Next, for the caps in place to limit reductions in fee schedule payments during the phase-in period, the timing is changed. Specifically, tests furnished during 2021–2024 (rather than 2021–2023) are to be paid at the same rates as under the 2020 fee schedule, and payments for tests provided during 2025–2027 (rather than 2024–2026) may not be reduced by more than 15 percent per year.

The *National Defense Authorization Act for Fiscal Year 2024* (Public Law 118-31, enacted on December 22, 2023) included provisions that affect the HI and SMI programs.

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 month, through October 31, 2032. (In other words, the benefit payment reductions for the month of October 2032 are changed from 0 percent to 2 percent.)
- The funding amount of $466,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-22, is increased to $2,250,795,056.

The *Further Continuing Appropriations and Other Extensions Act, 2024* (Public Law 118-35, enacted on January 19, 2024) included provisions that affect the HI and SMI programs.

- The funding amount of $2,250,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-31, is reduced to $2,197,795,056.
- The 1.00 floor on the geographic index for physician work is extended through March 9, 2024 (from January 20, 2024).

For Part A and Part D there was no change in the present values of estimated income and expenditures. For Part B, these changes resulted in a slight decrease in the present value of estimated expenditures (and income). Overall, these changes had no impact on the present value of the estimated future net cash flow for total Medicare.

For the period beginning on January 1, 2022 to the period beginning on January 1, 2023

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions had a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

The *Postal Service Reform Act of 2022* (Public Law 117-108, enacted on April 6, 2022) included one provision that affects Parts B and D of the SMI program.

- A new Postal Service Health Benefits (PSHB) program, which will provide health insurance to United States Postal Service (USPS) employees, annuitants, and their eligible family members, is established, with an implementation date of January 1, 2025. The program will be structured similarly to, and established within, the Federal Employees Health Benefits (FEHB) program, with a selection of health insurance plans from which to choose. To participate in the PSHB program, most USPS annuitants and eligible family members who are newly entitled to premium-free Medicare Part A as of January 1, 2025 must be enrolled in Part B as well. Prior to this new PSHB program, enrollment in Part B was voluntary for these individuals. (Those who turn age 64 on or before January 1, 2025 are exempted from this requirement. Also exempted are individuals who are current annuitants as of January 1, 2025, those living abroad, those enrolled in Veterans Administration coverage, and those eligible for services from the Indian Health Service.) In addition, PSHB plans will be required to offer Medicare Part D coverage for these newly entitled, Part D-eligible USPS annuitants and Part D-eligible family members. This legislation is expected to increase Part B enrollment somewhat and to increase Part D enrollment more significantly (particularly in employer/union-only group waiver plans).

The *Inflation Reduction Act of 2022* (Public Law 117-169, enacted on August 16, 2022) included provisions that affect the SMI programs.

- The Secretary of HHS is required to negotiate prices for certain prescription drugs covered under Medicare. Specifically, CMS (on behalf of the Secretary) must negotiate maximum fair prices for certain high-expenditure single-source Part B or Part D drugs (brand-name drugs without generic or biosimilar equivalents). The maximum fair prices that are negotiated for the first set of drugs subject to negotiation will be in effect beginning in 2026. The number of drugs subject to negotiation is phased in, such that CMS must negotiate the prices of (i) 10 drugs covered under Part D for 2026; (ii) 15 drugs covered under Part D for 2027; (iii) 15 drugs covered under Part B or Part D for 2028; and (iv) 20 drugs covered under Part B or Part D for 2029 and each year thereafter. The selected drugs must be among the 50 drugs with the highest total expenditures over the most recent 12-month period under Part B or Part D and must have been approved or licensed, as applicable, by the Food and Drug Administration for at least 7 years (for drug products) or 11 years (for biologics). Excluded are (i) certain orphan drugs that are approved to treat only one rare disease or condition; (ii) plasma-derived products; (iii) drugs that account for less than $200 million in annual Medicare spending (in 2021 and adjusted annually for inflation); and (iv) certain small biotech drugs (for 2026, 2027, and 2028). Manufacturers of drugs selected for negotiation that fail to comply with negotiation requirements are subject to civil penalties and/or excise taxes. If certain requirements are met, negotiations for certain biologics may be delayed for up to 2 years upon request by a manufacturer of a

biosimilar for which the biologic is the reference product. Funds in the amount of $3 billion in FY 2022 are provided to CMS, and are to remain available until expended, for the implementation of this provision.

- For Part B, with respect to each quarter beginning January 1, 2023, and for Part D, with respect to each 12-month applicable period beginning October 1, 2022, drug manufacturers must pay rebates to Medicare if they increase drug prices for a rebatable Part B or Part D drug at a rate that is faster than the rate of consumer inflation. In general, for both Part B and Part D, rebatable drugs include certain drugs and biologics that meet the statutory criteria and have an average cost of $100 or more per year per person, as determined by the Secretary. Manufacturers that fail to comply are subject to civil penalties. Beginning April 1, 2023, beneficiary coinsurance under Part B for a Part B rebatable drug will be adjusted downward to reflect inflation-adjusted payment amounts if the drug price increased more rapidly than the rate of inflation. Funds in FY 2022–2031 are provided to CMS for the implementation of this provision.
- For insulin furnished under Part B through durable medical equipment, the Part B deductible is waived, and cost sharing is not to exceed $35 per monthly prescription, effective July 1, 2023.
- For insulin products covered under each Part D plan and during all phases of the Part D benefit, beginning January 1, 2023, the deductible does not apply with respect to such products, and cost sharing for a 1-month supply of each covered insulin product must not exceed $35. (For plan year 2023, plans will receive retrospective subsidies equal to the difference between the plans' benefit packages, as submitted and approved under their 2023 bids, and the $35 statutory limit.) For plan years 2026 and later, when the negotiated maximum fair prices for selected drugs will be in effect, the cost sharing for each month's supply for covered insulin under Part D must be limited to the least of (i) the $35 copayment; (ii) 25 percent of the insulin's negotiated price under the plan; or (iii) 25 percent of the insulin's negotiated maximum fair price.
- For biosimilar products separately payable under Part B and administered in physician offices, hospital outpatient departments, and ambulatory surgical centers with an average sale price (ASP) of not more than the price of their associated reference biological product, the add-on payment (which is paid in addition to the biosimilar's ASP) is temporarily raised from 6 percent to 8 percent of the reference product's ASP for 5 years. The add-on payment for biosimilars that do not meet the ASP qualification will continue to be 6 percent of the reference biological product's ASP. (For existing qualifying year biosimilars for which payment was based on the ASP as of September 30, 2022, the 5-year period began on October 1, 2022. For new qualifying biosimilars for which payment based on the ASP is first made between October 1, 2022 and December 31, 2027, the 5-year period begins on the first day of the calendar quarter during which such payment is made.)
- For new biosimilar products furnished under Part B on or after July 1, 2024, the payment rate during the initial period, when an ASP is unavailable, will be the lesser of (i) the biosimilar's wholesale acquisition cost plus 3 percent or (ii) 106 percent of the associated reference biological product's ASP.
- The standard Part D benefit design (for beneficiaries not eligible for cost sharing and/or premium subsidies) is restructured as follows:
  - (i) In 2024 and later, the 5-percent cost sharing currently required from the beneficiary during the catastrophic coverage phase (that is, after the beneficiary reaches the out-of-pocket threshold) is eliminated, thereby capping previously unlimited out-of-pocket costs for the beneficiary at the out-of-pocket threshold level. The allowed costs in the catastrophic coverage phase will be borne by the drug plan and by Medicare, at 20 percent and 80 percent, respectively, in 2024 (as opposed to the current catastrophic cost distribution of 5 percent from the beneficiary, 15 percent from the drug plan, and 80 percent from Medicare).
  - (ii) Beginning in 2025, enrollees will have a $2,000 limit on their out-of-pocket costs for covered Part D drugs; that is, neither the initial coverage limit nor the period currently referred to as the coverage gap

(the phase between the initial coverage limit and the out-of-pocket threshold)[10] will continue to exist, and the out-of-pocket cap for entering the catastrophic coverage phase (during which there will no longer be beneficiary cost sharing, as described above) will be reduced to $2,000. For 2026 and later, this $2,000 limit will be increased by the annual percentage increase used for other Part D benefit parameters.

(iii) Also beginning in 2025, for the entire period starting after the deductible is met and ending when the catastrophic coverage phase begins, beneficiary cost sharing will be 25 percent for drugs that are neither insulins nor specified vaccines. The remaining allowed costs (after the 25-percent beneficiary cost sharing) will be covered, in general, as follows: (i) for applicable drugs, by a 10-percent discount paid by the drug manufacturer[11] and a 65-percent benefit from the beneficiary's Part D plan, and (ii) for non-applicable drugs, by a 75-percent benefit from the beneficiary's Part D plan. (In contrast, through 2024, the Part D plan covers 75 percent of the remaining allowed costs until the beneficiary enters the coverage gap; then, during the coverage gap, the remaining allowed costs are covered as follows: (i) for applicable drugs, by a 70-percent discount paid by the drug manufacturer and a 5-percent benefit from the Part D plan, and (ii) for non-applicable drugs, by a 75-percent benefit from the Part D plan.) Applicable drugs are generally covered brand-name Part D drugs and biologics, including biosimilars; *non-applicable* drugs are generally covered non-brand-name—that is, generic—Part D drugs.

The 10-percent discount paid by the manufacturer will not count toward the out-of-pocket threshold. (In contrast, the dollar value of the 70-percent manufacturer discount for applicable drugs in 2024 is included in a beneficiary's progression toward meeting the out-of-pocket threshold, even though the beneficiary does not pay it. However, certain third-party payments will count as the beneficiary's own out-of-pocket spending, including amounts reimbursed by insurance (which is not the case through 2024). The low-income subsidies currently provided under Part D and from State Pharmacy Assistance programs will continue to count toward the out-of-pocket amount.

(iv) In addition, and also beginning in 2025, the cost coverage distribution during the catastrophic coverage phase will change (from the distribution in 2024, which was previously described). Specifically, (i) Medicare's share will decrease from 80 percent (for all covered prescription drugs) to 20 percent for applicable drugs and to 40 percent for non-applicable drugs; (ii) drug manufacturers[12] will be required, in general, to provide a 20-percent discount on applicable drugs (whereas no manufacturer discount is required in the catastrophic phrase prior to 2025); and (iii) the 20-percent share borne by Part D plans will increase to 60 percent.

(v) Starting in 2025, all enrollees will have the option from their Part D plans to pay out-of-pocket costs spread out in capped, monthly amounts over the plan year (instead of paying as the costs are incurred).

- For each of plan years 2024–2029, the base beneficiary premium increase is to be limited to no more than 6 percent from the prior year. Premiums for some Part D plans may increase by more than 6 percent per year during this period, but the national average is constrained. For plan years 2030 and later, CMS may

[10]Originally, when the Part D program began, the beneficiary had to pay the full cost of prescription drugs while in this phase (hence the term *coverage gap*). However, legislation enacted in 2010 and 2018 phased down the out-of-pocket cost-sharing percentage for beneficiaries in the coverage gap over the period 2010–2020 such that, beginning in 2020, the coverage gap was fully closed, with the beneficiary responsible for 25 percent of all prescription drug costs (that is, the same percentage that is paid by the beneficiary during the initial coverage phase, when the beneficiary has met the deductible but has not yet reached the initial coverage limit).

[11]For most applicable drugs, the 10-percent responsibility will be paid by the manufacturer, but for selected drugs there will be a government subsidy for this amount rather than a manufacturer discount. Additionally, for low-income beneficiaries and for small biotech drugs, this amount will be phased in gradually.

[12]For most applicable drugs, the 20-percent responsibility will be paid by the manufacturer, but for selected drugs there will be a government subsidy for this amount rather than a manufacturer discount. Additionally, for low-income beneficiaries and for small biotech drugs, this amount will be phased in gradually.

determine a new beneficiary premium percentage, based on the 2029 constrained premiums, to replace the current value of 25.5 percent. This new percentage may not be less than 20 percent.

- Effective January 1, 2024, Part D low-income subsidies are expanded. Specifically, (i) the income limit for individuals to qualify for the full subsidy will increase from 135 percent to 150 percent of the Federal poverty level (FPL) (whereas, previously, individuals with incomes between 135 percent and 150 percent of the FPL had been eligible for only a partial subsidy); and (ii) the limit on resources required for the full subsidy will also increase (from the limit that had been in place for the partial subsidy, which will no longer exist).
- Effective January 1, 2023, Part D plans may not apply a deductible, coinsurance, or other enrollee cost-sharing amount for Part D-covered adult vaccines recommended by the Advisory Committee on Immunization Practices, such as the shingles (herpes zoster) vaccine. (By comparison, preventive vaccines required by statute to be covered under Part B already have no enrollee cost sharing, except for those vaccines used to treat an injury or exposure to a disease.)

The *Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023* (Public Law 117-180, enacted on September 30, 2022) included provisions that affect the HI and SMI programs.

- Medicare inpatient hospital add-on payments for certain low volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) are extended through December 16, 2022 (from September 30, 2022). The sliding scale used to determine the add-on percentages is also extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2022, is extended through December 16, 2022. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

The *Further Continuing Appropriations and Extensions Act, 2023* (Public Law 117-229, enacted on December 16, 2022) included provisions that affect the HI and SMI programs.

- Medicare inpatient hospital add-on payments for certain low-volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) are extended through December 23, 2022 (from December 16, 2022). The sliding scale used to determine the add-on percentages is also extended. (See Public Law 117-180.)
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 16, 2022 (as described under Public Law 117-180), is extended through December 23, 2022. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)

The *Consolidated Appropriations Act, 2023* (Public Law 117-328, enacted on December 29, 2022) included provisions that affect the HI and SMI programs.

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by 1 year, through FY 2032 (which, for sequestration purposes, covers April 1, 2032 through March 31, 2033). The benefit payment reductions for this newly added 12-month period are set at 2 percent for the first 6 months and 0 percent for the final 6 months. In addition, the benefit payment reductions for FY 2030 and 2031 (covering April 1, 2030 through March 31, 2032) are changed back to a

uniform 2 percent for the entire period (from 2.25 percent, 3 percent, 4 percent, and 0 percent for the first, second, third, and final 6-month periods, respectively).

- The 1-percent add-on payment is extended for 1 year (through December 31, 2023) for those home health agencies that serve beneficiaries in rural areas and that are classified in the low-population-density tier. (This tier is one of three used for determining rural add-on adjustments. The tiers are based on Medicare home health utilization and population density.)
- Medicare inpatient hospital add-on payments for certain low-volume hospitals (those with fewer than 3,800 total discharges annually and located 15 road miles or more from the nearest like hospital) are extended through September 30, 2024 (from December 23, 2022). The sliding scale used to determine the add-on percentages is also extended. (See Public Law 117-229.)
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 23, 2022 (as described under Public Law 117-229), is extended through September 30, 2024. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals, in light of what had been the impending expiration of the MDH program, may decline this reclassification and reinstate their MDH status.)
- Beginning in 2026, an additional 200 Medicare graduate medical education (GME) residency positions are provided for, half of which are to be reserved for psychiatry and psychiatry-subspecialty residencies.
- In the formula for determining payment rates under the physician fee schedule, the updates to the conversion factor are changed to be −0.5 percent, −1.2 percent, and −1.2 percent in 2023, 2024, and 2025, respectively (replacing −2.9 percent for 2023 and 0 percent for 2024 and 2025).
- Certain ground ambulance add-on payments that had been extended through December 31, 2022 under previous legislation are now extended through December 31, 2024. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.
- For physicians participating in advanced alternative payment models, a 1-year extension of incentive payment availability is provided, but the payments will be at 3.5 percent. (In recent years, physicians could earn a 5-percent incentive payment, but only through the end of performance year 2022, which is payment year 2024.) In addition, the current freeze on participation thresholds that must be met to qualify for the incentive payments is extended for an additional year (that is, for payment year 2025, which is performance year 2023).
- For the market-based system used to update the Medicare clinical laboratory fee schedule, laboratories are exempted for another year from the requirement that they report private payer rates. The next data-reporting period is now the first quarter of 2024 (instead of the first quarter of 2023). Also, during the phase-in period for this system, the caps in place to limit reductions in fee schedule payments from year to year are changed to 0 percent for 2022–2023 and 15 percent for 2024–2026 (as opposed to the previous statutory parameters of 0 percent for 2021–2022 and 15 percent for 2023–2025). That is, tests furnished under the fee schedule during 2022–2023 are to be paid at the same rates as under the 2021 fee schedule, and payments may not be reduced by more than 15 percent for services provided during 2024–2026.
- Marriage and family therapists and mental health counselors are allowed to receive payment from Part B for providing covered mental health services to beneficiaries, beginning January 1, 2024. (The qualifications for these professions are defined in the provision.)
- Effective January 1, 2024, Medicare's partial hospitalization benefit (which provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care) is revised to provide coverage of intensive outpatient services.

- The use of blended payment rates for durable medical equipment in certain non-competitive bid areas, as provided for during the public health emergency by Public Law 116-136, is extended through December 31, 2023.
- Compression garments furnished on or after January 1, 2024 for the treatment of lymphedema are covered under Part B as durable medical equipment.

The net impact of all legislative changes was a small increase in the estimated future net cash flow for total Medicare. For Part A the present value of estimated expenditures is slightly lower. The present values of estimated income and expenditures are much lower for Part B and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $1 billion.

Required Supplementary Information

Combining Statement of Budgetary Resources

For the Year Ended September 30, 2024
(in Millions)

	CMS					
	Medicare HI	Medicare SMI	Payments to Trust Funds	Medicaid	Other Agency Accounts	Agency Combined Totals
Budgetary Resources						
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 153	$ 199	$ 239,799	$ 47,428	$ 116,427	$ 404,006
Appropriations (Discretionary and Mandatory)	388,681	525,840	548,372	633,231	342,737	2,438,861
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	86	86
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	1,718	19,900	21,618
Total Budgetary Resources	**$ 388,834**	**$ 526,039**	**$ 788,171**	**$ 682,377**	**$ 479,150**	**$ 2,864,571**
Status of Budgetary Resources						
New Obligations and Upward Adjustments	$ 388,834	$ 526,039	$ 542,896	$ 682,336	$ 378,640	$ 2,518,745
Unobligated Balance, End of Year:						
Apportioned, Unexpired Accounts	-	-	5,488	41	55,877	61,406
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	1,657	1,657
Unapportioned, Unexpired Accounts	-	-	5	-	19,322	19,327
Unexpired Unobligated Balance, End of Year	-	-	5,493	41	76,856	82,390
Expired Unobligated Balance, End of Year	-	-	239,782	-	23,654	263,436
Unobligated Balance, End of Year	-	-	245,275	41	100,510	345,826
Total Status of Budgetary Resources	**$ 388,834**	**$ 526,039**	**$ 788,171**	**$ 682,377**	**$ 479,150**	**$ 2,864,571**
Outlays, Net						
Outlays, Net (Discretionary and Mandatory)	$ 407,378	$ 525,704	$ 519,483	$ 610,988	$ 358,311	$ 2,421,864
Distributed Offsetting Receipts	(54,033)	(644,013)	-	-	(2,819)	(700,865)
Agency Outlays, Net (Discretionary and Mandatory)	**$ 353,345**	**$ (118,309)**	**$ 519,483**	**$ 610,988**	**$ 355,492**	**$ 1,720,999**
Disbursements, Net	**$**	**$**	**$**	**$**	**$ 71**	**$ 71**

Summary of Other Agency Accounts

	Budgetary Resources	Outlays, Net
ACF	$ 85,030	$ 81,777
ACL	2,788	2,792
AHRQ	418	370
ASPR	3,682	672
CDC	24,688	18,696
CMS	232,887	150,406
FDA	9,128	3,839
HRSA	16,772	14,573
IHS	18,296	8,519
NIH	59,588	47,719
OS	14,442	16,429
PSC	2,499	812
SAMHSA	8,932	8,888
Totals	**$ 479,150**	**$ 355,492**

Deferred Maintenance and Repairs

The FASAB issued SFFAS 42, *Deferred Maintenance and Repairs*: *Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32,* effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices and improve reporting on Deferred Maintenance and Repairs (DM&R). DM&R are maintenance and repair activities not performed when they should have been or were scheduled to be and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed capital assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components, and other activities needed to preserve the asset so that it continues to provide acceptable service. Other factors under consideration are whether the asset meets applicable building codes and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized when incurred. HHS DM&R relates solely to capitalized Property, Plant, and Equipment (PP&E). HHS tracks replacement value, repair needs data elements, and backlogs of maintenance and repair for owned buildings and structures.

HHS land holding Divisions prioritize maintenance and repair activities by employing capital planning processes consistent with OMB Circular No. A-11, prioritizing assets based on the Division's strategic goals. Annually, Divisions update their Division Real Property Capital Plans and include a detailed narrative of planning procedures for acquisition, maintenance, operations, and disposal projects for the budget year and five years forward.

HHS uses industry standard criterion, Condition Index (CI) Formula [CI = 1 – (DM&R/Plant Replacement Value (PRV))], to determine acceptable condition standards. A CI of 90 or above is considered good, while a CI below 90 is considered progressively poor condition. Inflation in labor and material costs for DM&R are estimated in accordance with HHS Budget Justification Guidance, where the most current inflation rate specified by OMB is used to project escalations.

Estimated Cost to Return to Acceptable Condition
(in Millions)

Category of Asset	2024	2023
PP&E		
Buildings	$ 4,919	$ 5,094
Other Structures	34	31
Total	**$ 4,953**	**$ 5,125**

The decrease of $172 million in DM&R is primarily due to disposal of assets and capital investment projects that allowed more repairs to be completed in FY 2024 than in FY 2023.

Land

HHS land is categorized as general PP&E and Operational per SFFAS 59, *Accounting and Reporting of Government Land*. IHS land hosts hospitals and public-facing health centers across the country and NIH land hosts research campuses primarily in Maryland, North Carolina, Montana, and Arizona. The table below provides the detail by OpDiv and total estimated acreage.

Estimated Acreage by Predominant* Use

	Operational				
	CDC	FDA	IHS	NIH	Total Estimated Acreage
PP&E Land					
Start of Prior Year	474	729	2,152	1,317	4,672
End of Prior Year/Start of Current Year	941	730	2,087	1,319	5,077
End of Current Year	941	730	2,354	1,312	5,337
Stewardship Land					
Start of Prior Year	-	-	1,108	-	1,108
End of Prior Year/Start of Current Year	-	-	1,115	-	1,115
End of Current Year	-	-	1,115	-	1,115
Held for Disposal or Exchange					
End of Prior Year	-	-	5	-	5
End of Current Year	-	-	6	-	6

* "Predominant use" is defined by SFFAS 59, *Accounting and Reporting of Government Land*, and does not affect provisions governing land use.

Estimated Acreage for Stewardship Land

IHS Area	2024	2023
Albuquerque	17	17
Bemidji	23	23
Billings	118	118
Great Plains	185	185
Navajo	703	703
Oklahoma City	6	6
Phoenix	30	30
Portland	3	3
Tucson	30	30
Total	**1,115**	**1,115**

Social Insurance

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

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

RSI material is generally drawn from the *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (the Trustees Report), which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

With two exceptions, the projections are based on the current law provisions[13] of the *Social Security Act*. The first exception is that the Part A projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the Trustees Report would not fulfill one of its critical functions, which is to inform policymakers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted.

The second exception is that the elimination of the safe harbor protection for manufacturer rebates, which was finalized in a rule released in November of 2020, is not reflected in the Part D projections. This final rule imposed a January 1, 2022 effective date, however, implementation was initially delayed until January 1, 2023. Since then,

[13]Due to the timing and the limited effect on the financial outlook of the trust funds, the projections do not reflect the impact of the Medicare provisions in the *Consolidated Appropriations Act, 2024* (Public Law 118-42), which was enacted on March 9, 2024.

enacted legislation has three times imposed a moratorium on implementation, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The Medicare projections have been significantly affected by the enactment of the *Inflation Reduction Act of 2022*. This legislation has wide-ranging provisions, including those that restrain price growth and negotiate drug prices for certain Part B and Part D drugs and that redesign the Part D benefit structure to decrease beneficiary out-of-pocket costs. The law takes several years to implement, resulting in very different effects by year. The Part D benefit enhancements are implemented by 2025, for example, before the negotiation provisions that are effective in 2026 can have any spending reduction impact. The total effect of the *Inflation Reduction Act* is to reduce government expenditures for Part B, to increase expenditures for Part D from 2027 through 2030, and to decrease Part D expenditures beginning in 2031. Part B savings are due to the substantial lowering of payments, relative to current reimbursement, as a result of negotiated prices. Part D ultimately generates cost savings at the end of the 10-year period, but many of the gains from negotiated prices and lower trends are initially more than offset by increased benefits and decreased manufacturer rebates.

The Board of Trustees assumes that the *Inflation Reduction Act* will affect the ultimate long-range growth rates for Part B and Part D drug spending differently. For Part B drugs, since the Trustees do not anticipate that the market pricing dynamics will be much different from those prior to the implementation of the *Inflation Reduction Act*, they continue to assume that per capita spending growth rates will be similar to those for overall per capita national health expenditures. On the other hand, for Part D drugs, the Trustees assume that per capita spending will grow 0.2 percentage point more slowly than per capita national health expenditures, since the inflation provisions of the *Inflation Reduction Act* are likely to result in price growth that is lower than overall health prices and closer to the Consumer Price Index (CPI).

Beginning in 2020, the Medicare program was dramatically affected by the COVID-19 pandemic. Spending was directly affected by the coverage of testing and treatment of the disease. In addition, several regulatory policies and legislative provisions were enacted during the public health emergency that increased spending, and the use of telehealth was greatly expanded. More than offsetting these additional costs during the pandemic, spending for non-COVID care declined significantly.

Now that the public health emergency has ended and Medicare FFS per capita spending has stabilized, the Trustees place a greater reliance on recent experience when developing the cost projections. However, they continue to make three pandemic-related adjustments to the projections. The first is to account for the morbidity improvement in the surviving population, which is expected to continue to affect spending levels through 2029. The second adjustment accounts for the ending of the waiver regarding the 3-day inpatient stay requirement to receive skilled nursing facility services. The per capita spending projections typically include factors for price updates and changes in the utilization and mix of services. As a result of the Inflation Reduction Act of this waiver, the Trustees have increased their inpatient spending growth factor by 1.9 percentage points and decreased the skilled nursing facility spending growth factor by 7.5 percentage points in 2024. Finally, the third adjustment is to account for home health spending that was still, in 2023, significantly lower than estimated prior to the pandemic. As a result of the recent home health staffing shortages, the Trustees continue to consider the spending level for this service to be suppressed. Thus, they have increased their home health spending growth factor by 2.9 percentage points in each of the next 3 years (2024–2026).

Certain features of current law may result in some challenges for the Medicare program. This concern is more immediate for physician services, for which a negative payment rate update is projected for 2025 and updates are projected to be below the rate of inflation in all future years. Furthermore, additional payments totaling $500 million

per year and annual bonuses are scheduled to expire in 2025 and 2026, respectively. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business total factor productivity[14] although these health providers have historically achieved lower levels of productivity growth. Should payment rates prove to be inadequate for any service, beneficiaries' access to and the quality of Medicare benefits would deteriorate over time, or future legislation would need to be enacted that would likely increase program costs beyond those projected under current law.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws:

- *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012* (Public Law 112-240, enacted on January 2, 2013);
- *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013);
- Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014;
- *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014);
- *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015);
- *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018);
- *Bipartisan Budget Act of 2019* (Public Law 116-37, enacted on August 2, 2019);
- *Coronavirus Aid, Relief, and Economic Security Act* (Public Law 116-136, enacted on March 27, 2020);
- *Consolidated Appropriations Act, 2021* (Public Law 116-260, enacted on December 27, 2020);
- *Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes* (Public Law 117-7, enacted on April 14, 2021);
- *Infrastructure Investment and Jobs Act* (Public Law 117-58, enacted on November 15, 2021);
- *Protecting Medicare and American Farmers from Sequester Cuts Act* (Public Law 117-71, enacted on December 10, 2021);
- *Consolidated Appropriations Act, 2023* (Public Law 117-328, enacted on December 29, 2022); and
- *National Defense Authorization Act for Fiscal Year 2024* (Public Law 118-31, enacted on December 22, 2023).

The sequestration reduces benefit payments by the following percentages: 2 percent from April 1, 2013 through April 30, 2020; 1 percent from April 1, 2022 through June 30, 2022; and 2 percent from July 1, 2022 through October 31, 2032. Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through October 31, 2032, excluding May 1, 2020 through March 31, 2022 when it was suspended.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from current-law provisions that lower increases in Medicare payment rates to most categories of healthcare providers, but such adjustments would probably not be viable indefinitely without fundamental change in the current delivery system. It is conceivable that providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

[14]For convenience the term *economy-wide private nonfarm business total factor productivity* will henceforth be referred to as *economy-wide productivity*. Beginning with the November 18, 2021 release of the productivity data, the Bureau of Labor Statistics replaced the term *multifactor productivity* with the term *total factor productivity*, a change in name only as the underlying methods and data were unchanged.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting healthcare cost growth over time. The expenditure projections reflect the cost-reduction provisions required under current law. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law[15] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for healthcare productivity; (ii) the average physician payment updates would transition from current law[16] to payment updates that reflect the Medicare Economic Index; and (iii) the bonuses for qualified physicians in advanced alternative payment models (advanced APMs), which are expected to end after 2025, and the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire after 2024, would both continue indefinitely. The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the Trustees Report if the cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 26 in these financial statements, in Section V.C of this year's Trustees Report, and in a memorandum prepared by the CMS Office of the Actuary.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from the CMS website[17] (unaudited).

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[18] The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection.[19]

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010–2011 Technical Review Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of healthcare services for the total health sector and for Medicare. Therefore,

[15]Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth of economy-wide productivity (1.0 percent over the long range).
[16]The law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced alternative payment models (advanced APMs) or the merit-based incentive payment system (MIPS), respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.05 percent per year in the long range.
[17]The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation and is likewise not subject to audit by independent auditors.
[18]This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population, changes in the sex composition of the Medicare population, and changes in the distribution of the Medicare population on the basis of proximity to death, as the Trustees estimated these factors separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.
[19]The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010–2011 Medicare Technical Review Panel (final report available here (unaudited)) and with Finding 3-2 of the 2016–2017 Medicare Technical Review Panel (final report available here (unaudited)).

the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Medicare payment rates for most non-physician provider categories are updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the healthcare goods and services. These updates are then reduced by the 10-year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for five categories of healthcare provider services:

(i) *All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.*

HI services are inpatient hospital, skilled nursing facility, home health agency, and hospice. The primary Part B services affected are outpatient hospital, home health agency, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.7 percent in 2048, or GDP plus 0.0 percent, declining gradually to 3.4 percent in 2098, or GDP minus 0.3 percent.

(ii) *Physician services*

Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year cost growth rates for physician payments are assumed to decline from 3.3 percent in 2048, or GDP minus 0.4 percent, to 2.8 percent in 2098, or GDP minus 0.9 percent.

(iii) *Certain SMI Part B services that are updated annually by the CPI increase less the increase in economy-wide productivity.*

Such services include durable medical equipment that is not subject to competitive bidding,[20] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the year-by-year cost growth rates for these services to decline from 2.9 percent in 2048, or GDP minus 0.8 percent, to 2.6 percent in 2098, or GDP minus 1.1 percent.

(iv) *The remaining Part B services, which consist mostly of physician-administered drugs, laboratory tests, and small facility services.*

The Trustees assume that per beneficiary outlays for these other Part B services, which constitute about 35 percent of total Part B expenditures in 2033, grow at the same rate as the overall health sector as determined from the factors model. The services are assumed to grow similarly because their payments are established through market processes. For physician-administered Part B drugs, the key inflation provisions in the *Inflation Reduction Act* are not anticipated to affect such payments over the long range. The corresponding year-by-year cost growth rates decline from 4.4 percent in 2048, or GDP plus 0.7 percent, to 4.1 percent by 2098, or GDP plus 0.4 percent.

[20]The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process. For more information on the bidding process, see Section IV.B of the 2024 Trustees Report.

(v) *Prescription drugs provided through Part D.*

Medicare payments to Part D plans are based on a competitive-bidding process, and prior to the *Inflation Reduction Act* these payments were assumed to grow at the same rate as the overall health sector as determined from the factors model. While the negotiation provisions of the *Inflation Reduction Act* are not anticipated to affect the long-range growth rates for Part D drugs, the inflation provisions would likely lower these trends relative to previous expectations. Specifically, the *Inflation Reduction Act* requires the change in prices (before rebate adjustments) to be limited to the rate of growth in the CPI. Analysis of Part D pricing trends over recent years has consistently shown price growth in excess of the CPI, with a portion of these trends offset by increasing rebate percentages, and it was assumed, prior to the *Inflation Reduction Act*, that such trends would continue over the long range. The inflation provisions in the *Inflation Reduction Act* would likely lower these price trends, though it is expected that they would outpace the CPI due to certain manufacturer adaptations to the new law that may mitigate some of the pricing constraints, including new approaches regarding the development and release of new drugs. As a result, they are assumed to grow over the long range slightly more slowly than would be the case if they were determined strictly through market processes. The corresponding year-by-year cost growth rates decline from 4.2 percent in 2048, or GDP plus 0.5 percent, to 3.9 percent by 2098, or GDP plus 0.2 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. Beginning with the 2020 Trustees Report, these impacts reflect the changing distribution of Medicare enrollment by age, sex, and the beneficiary's proximity to death, which is referred to as a time-to-death (TTD) adjustment. The TTD adjustment reflects the fact that the closer an individual is to death, the higher his or her healthcare spending is. Thus, as mortality rates improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on healthcare is offset somewhat.[21] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing facility, and home health agency services—for which the distribution of spending is more concentrated in the period right before death. For Part B services and Part D, the incorporation of the TTD adjustment has a smaller effect.

After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.9 percent in 2048, or GDP plus 0.2 percent, declining to 3.6 percent by 2098, or GDP minus 0.1 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.9 percent, or GDP plus 0.2 percent in 2048, declining to 3.6 percent, or GDP minus 0.1 percent by 2098.

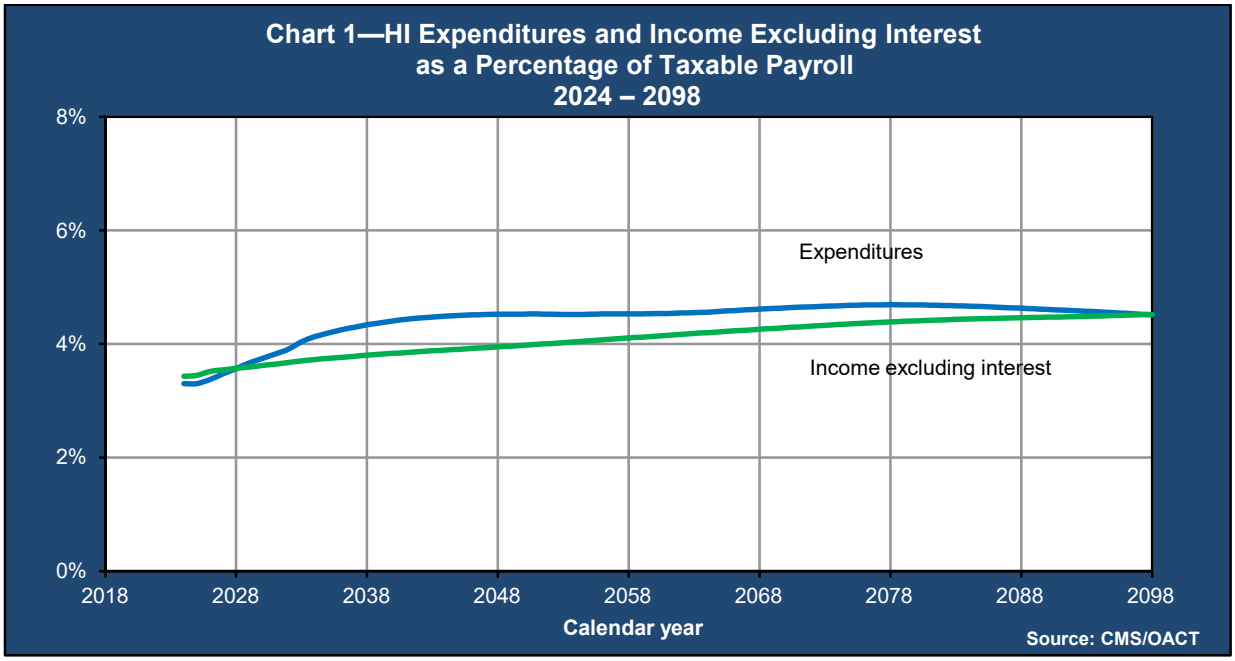
HI Cash Flow as a Percentage of Taxable Payroll

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

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates are lower than those from last year for all years because of (i) a policy change to exclude medical education expenses associated with Medicare Advantage (MA) enrollees from the fee-for-service per capita costs used in the development of MA spending, as described in Section IV.C of the Trustees Report, and

[21]More information on the TTD adjustment is available on the CMS website (unaudited).

(ii) lower spending for inpatient hospital and home health agency services due to a greater reliance on recent experience, as described in Section I of the Trustees Report.



Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers will become subject to a higher HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation; this outcome will occur because the income thresholds determining taxable benefits are not indexed for price inflation and because the income tax brackets are indexed to the chained CPI (C-CPI-U), which increases at a slower rate than average wages. After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the C-CPI-U as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as, rather than significantly faster than, taxable payroll.[22] Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

After remaining steady in 2023 through 2025, as indicated in Chart 1, the cost rate is projected to rise in 2026 and beyond primarily due to an acceleration of health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.5 percent through 2033 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 4.9 percent in 2049 and 6.8 percent in 2098.

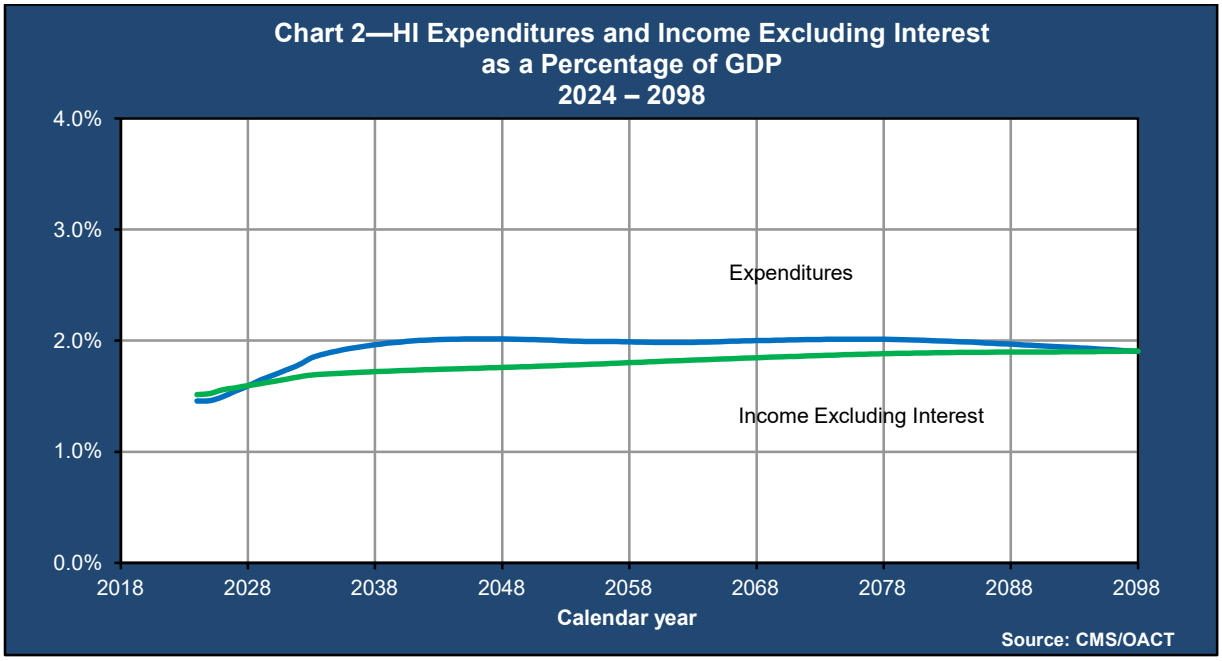
[22]See Section V.C7 of the *2024 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* for more detailed information on the projection of income from taxation of Social Security benefits.

HI and SMI Cash Flow as a Percentage of GDP

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

HI

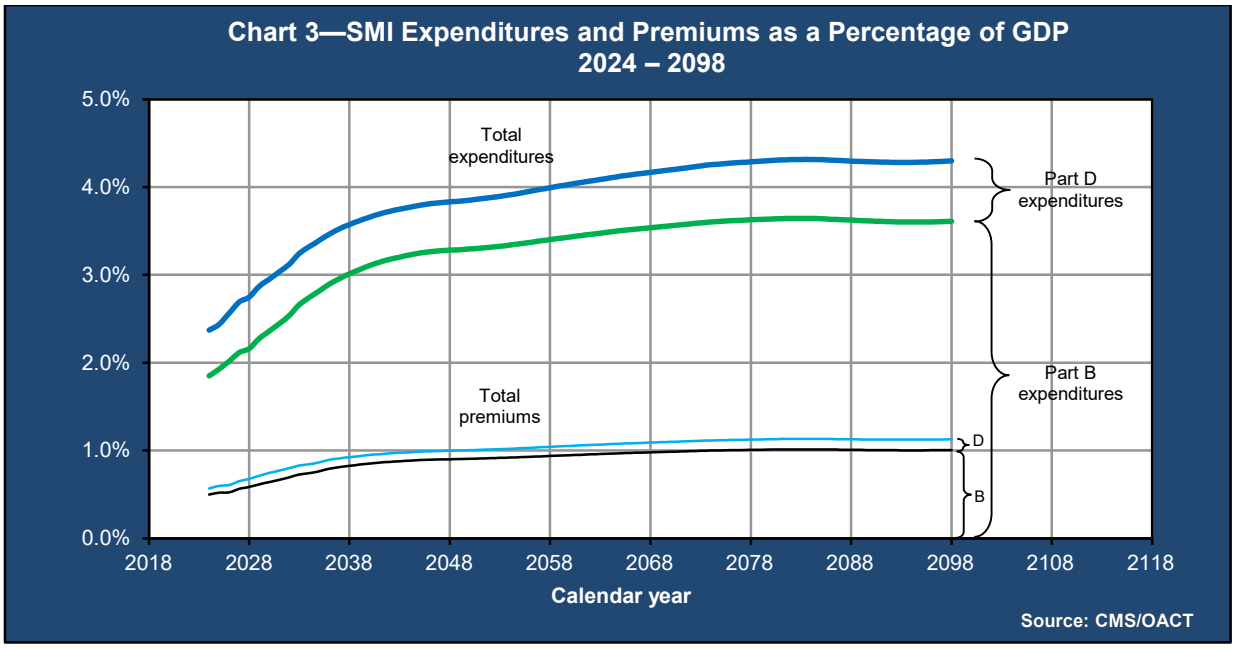
Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2023, the expenditures were $403.1 billion, which was 1.5 percent of GDP. As Chart 2 illustrates, this percentage is projected to increase steadily until about 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 2.9 percent in 2098.



SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and government contributions, which are transfers from the general fund of the Treasury.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.



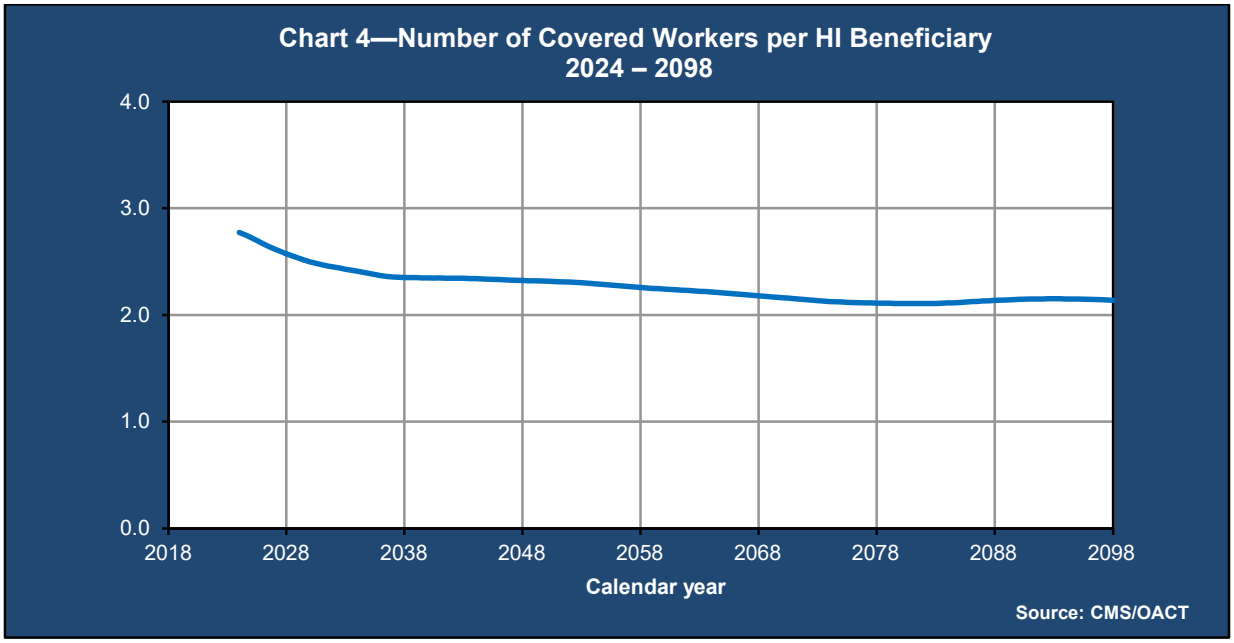
In 2023, SMI expenditures were $633.9 billion, or about 2.3 percent of GDP. Under current law, they would grow to about 3.8 percent of GDP within 25 years and to 4.3 percent by the end of the projection period, as demonstrated in Chart 3. Under the illustrative alternative, total SMI expenditures in 2098 would be 5.5 percent of GDP.

To match the faster growth rates for SMI expenditures, government contributions and beneficiary premiums would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2023 by about 4.2 percent annually. The associated beneficiary premiums—and general fund financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. State payments have increased faster than GDP for most years since 2015 and are projected to do so for most of the long-range period; for most of the short-range period, however, they are projected to increase more slowly than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation.



In 2023, every beneficiary had about 2.8 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.5 workers for each beneficiary, as indicated in Chart 4. The projected ratio continues to decline until there are only 2.1 workers per beneficiary by 2098.

Sensitivity Analysis

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

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[23] The assumptions varied are the healthcare cost factors, real-wage growth, CPI, real interest rate, fertility rate, and net immigration.[24]

For this analysis, the intermediate economic and demographic assumptions in the 2024 Trustees Report are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2024, and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 15 to 20 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Healthcare Cost Factors

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

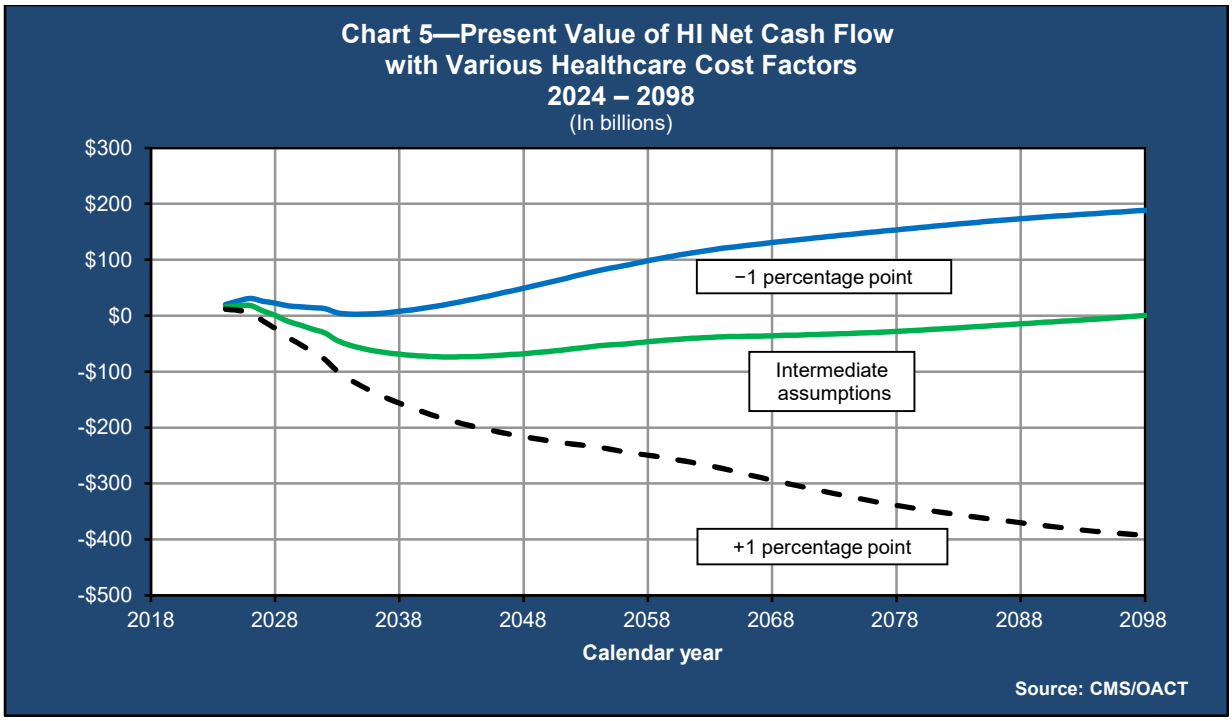
Table 1—Present Value of Estimated HI Income Less Expenditures under Various Healthcare Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$7,367	−$2,618	−$18,606

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $9,985 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $15,988 billion.

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

[23]Sensitivity analysis is not done for Parts B or D of the SMI trust fund because of the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.
[24]The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.



This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus because of the improved financial outlook for the HI trust fund as a result of the cost-reduction provisions required under current law. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for healthcare service costs.

Real-Wage Growth

Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage growth assumptions: 0.53, 1.14, and 1.74 percentage points.[25] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent.

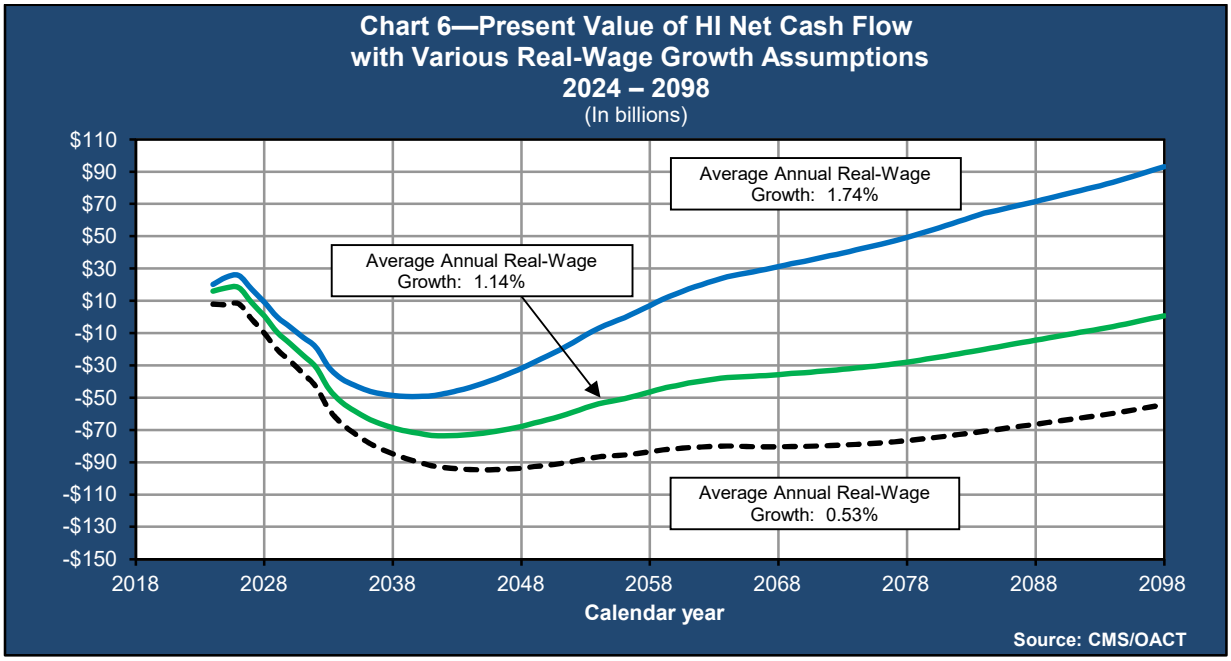
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Growth Assumptions

Ultimate percentage increase in real-wage growth	0.53	1.14	1.74
Income minus expenditures (in billions)	−$5,262	−$2,618	$1,364

As indicated in Table 2, for a 0.6 percentage point increase in the ultimate real-wage growth assumption, the deficit-expressed in present-value dollars—decreases by approximately $3,983 billion. Conversely, for a 0.6 percentage point decrease in the ultimate real-wage growth assumption, the deficit increases by about $2,600 billion.

[25]Real-wage growth is the annual percentage change in average covered wages adjusted for the average percentage change in the CPI.

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



When expressed in present-value dollars, faster real-wage growth results in smaller HI cash flow deficits, as demonstrated in Chart 6. Higher real-wage growth immediately increases both HI expenditures for healthcare and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all healthcare costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the cost-reduction provisions depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers.

Consumer Price Index

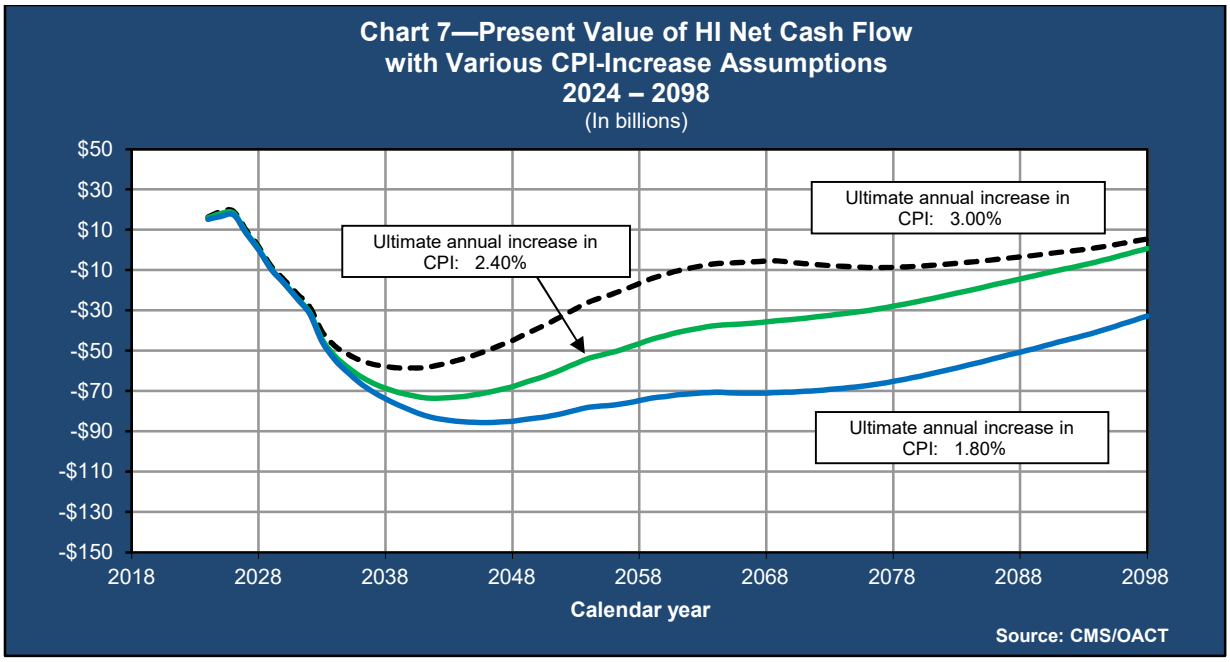
Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the ultimate real wage growth assumption is 1.14 percent.

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

Ultimate percentage increase in CPI	3.00	2.40	1.80
Income minus expenditures (in billions)	−$1,346	−$2,618	−$4,408

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by about $1,273 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $1,790 billion.

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



This assumption has a small impact when the cash flow is expressed as present values, as Chart 7 indicates. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Real-Interest Rate

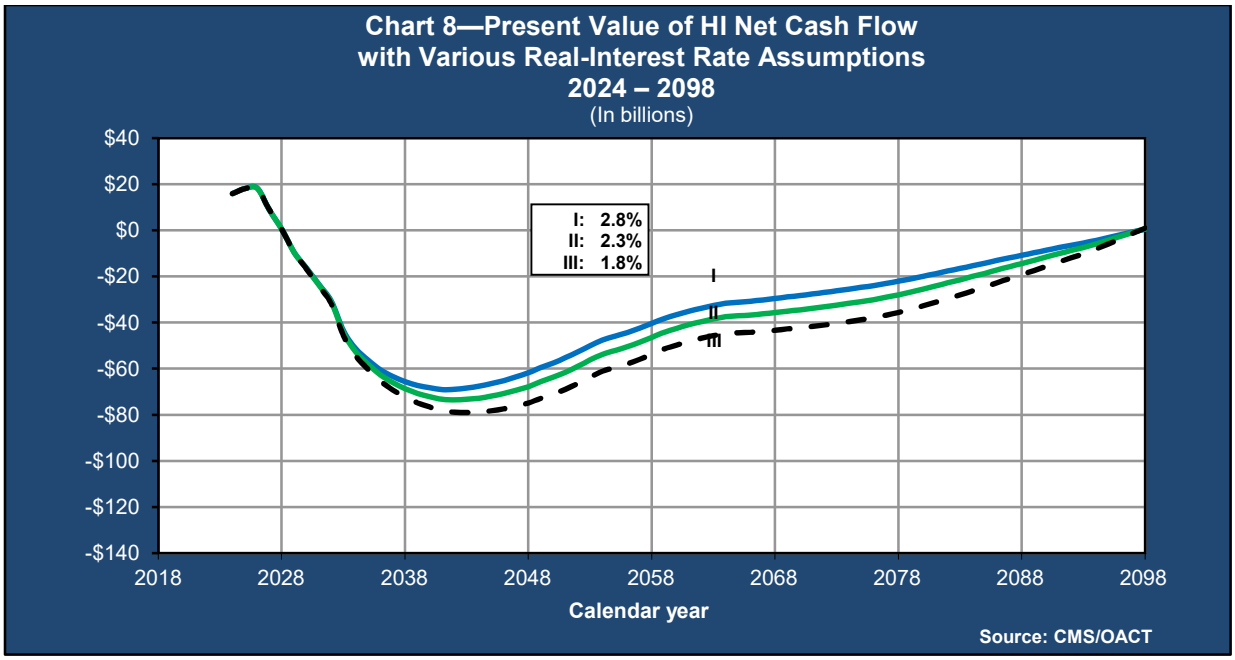
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real interest assumptions: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 4.2, 4.8, and 5.3 percent, respectively.

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

Ultimate real-interest rate	1.8 percent	2.3 percent	2.8 percent
Income minus expenditures (in billions)	-$3,003	-$2,618	-$2,310

As demonstrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $70 billion.

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



The projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption, as shown in Chart 8. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2036. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.6, 1.9, and 2.1 children per woman.

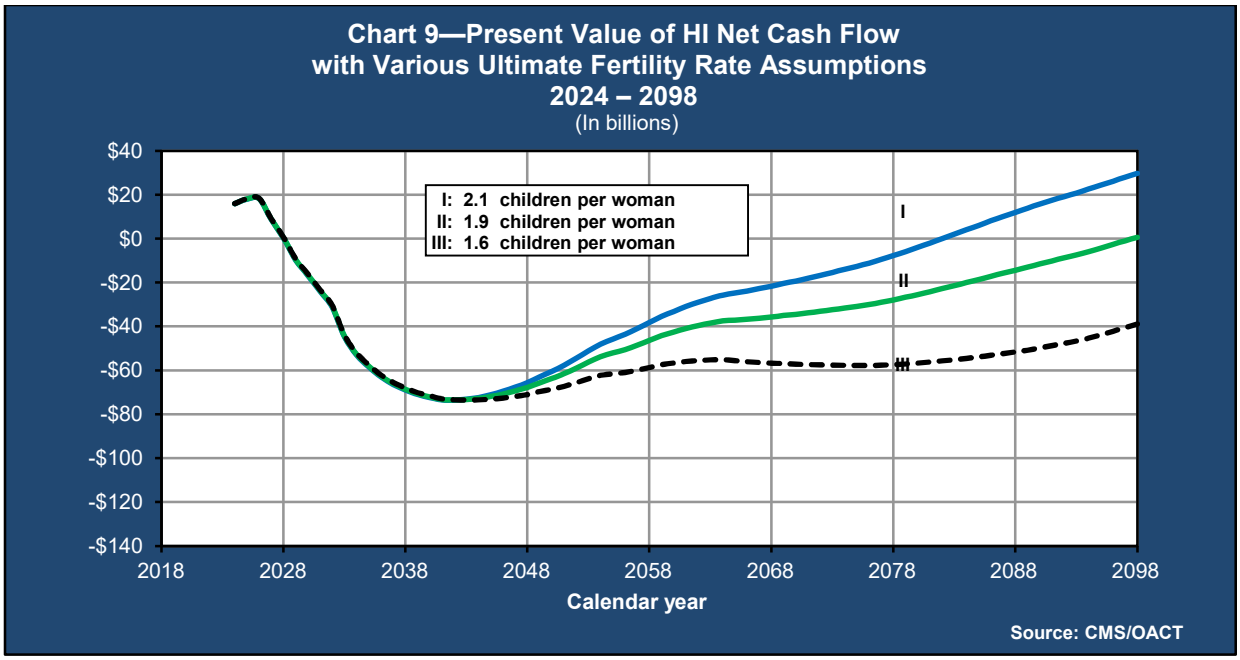
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.6	1.9	2.1
Income minus expenditures (in billions)	−$3,861	−$2,618	−$1,755

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

As Table 5 demonstrates, for every increase of 0.1 percentage point in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $425 billion.

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



The fertility rate assumption has a substantial impact on projected HI cash flows, as Chart 9 indicates. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, and many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

Net Immigration

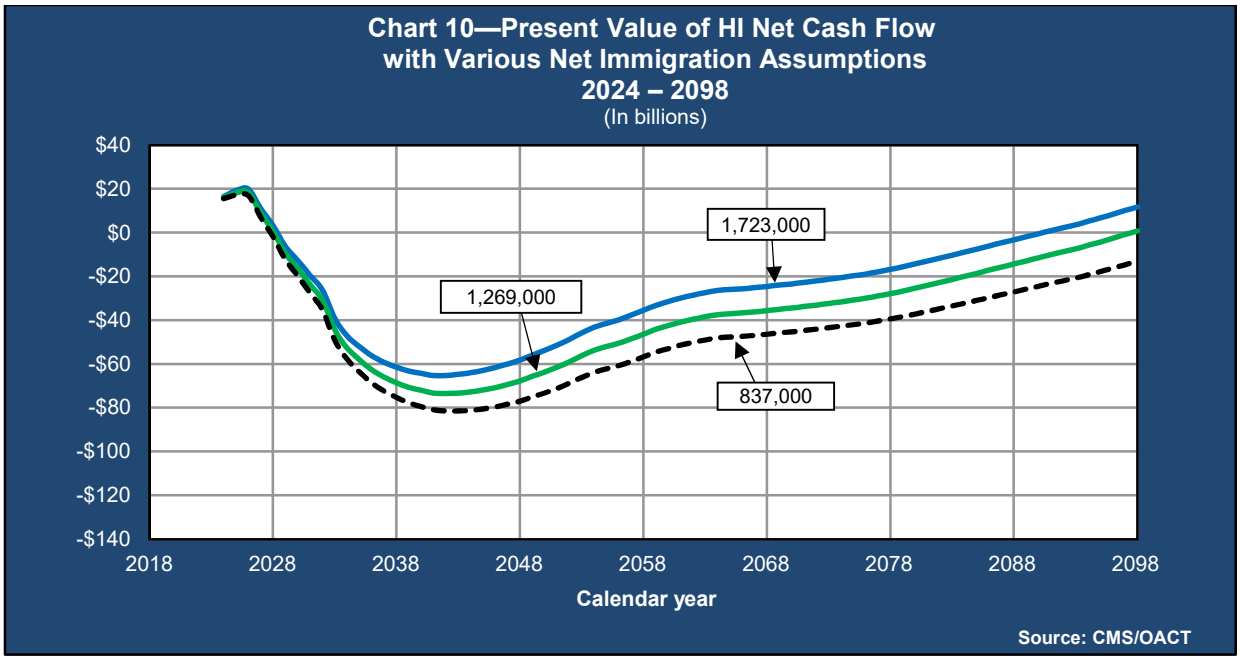
Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 837,000 persons, 1,269,000 persons, and 1,723,000 persons per year.

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

Average annual net immigration	837,000	1,269,000	1,723,000
Income minus expenditures (in billions)	−$3,330	−$2,618	−$1,927

As indicated in Table 6, if the average annual net immigration assumption is 837,000 persons, the deficit—expressed in present-value dollars—increases by approximately $711 billion. Conversely, if the assumption is 1,723,000 persons, the deficit decreases by $691 billion.

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



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

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is more favorable than the projections in last year's Medicare Trustees Report. The estimated depletion date for the HI trust fund is 2036, 5 years later than projected in last year's Trustees Report. HI income is projected to be higher than last year's estimates because both the number of covered workers and average wages are projected to be higher. HI expenditures are projected to be lower than last year's estimates through the short-range period mainly as a result of (i) a policy change to exclude medical education expenses associated with MA enrollees from the fee-for-service per capita costs used in the development of MA spending and (ii) spending for inpatient hospital and home health agency services that is lower than previously estimated due to a greater reliance on recent experience.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018, 2019, and 2020, expenditures again exceeded income, with trust fund deficits of $1.6 billion, $5.8 billion, and $60.4 billion, respectively. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund. In 2021, there was a small surplus of $8.5 billion as these payments began to be repaid to the trust fund, and this continued repayment resulted in a larger surplus in 2022 of $53.9 billion. There was another small surplus of $12.2 billion in 2023. The Trustees project that surpluses will continue through 2029, followed by deficits until the trust fund becomes depleted in 2036. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs.

Beneficiary access to healthcare services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policymakers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

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

The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general fund transfers for each part, are sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI trust fund is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program outlays and dedicated financing sources[26] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2024–2030). For the 2024 Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2027, and therefore the Trustees are issuing this determination. Since this determination was made last year as well, this year's determination triggers a Medicare funding warning, which (i) requires the President to submit to Congress proposed legislation to respond to the warning within 15 days after the submission of the Fiscal Year 2026 Budget and (ii) requires Congress to consider the legislation on an expedited basis. Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 through 2023 reports. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2024 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policymakers to "work closely together to expeditiously address these challenges."

[26]Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State payments for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

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SECTION 3:

OTHER INFORMATION

- Other Financial Information
- Summary of Financial Statement Audit and Management Assurances
- Civil Monetary Penalty Adjustment for Inflation
- Grants Closeout Reporting
- Payment Integrity Report
- FY 2024 Top Management and Performance Challenges Identified by the Office of Inspector General
- Department's Response to the Office of Inpector General

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Other Financial Information

Consolidating Balance Sheet by Budget Function

As of September 30, 2024

(in Millions)

	Education, Training & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra HHS Eliminations	HHS Consolidated Totals
Assets (Note 2)							
Intragovernmental Assets							
Fund Balance with Treasury (Note 3)	$ 18,953	$ 343,880	$ 267,906	$ 46,205	$ 676,944	$ -	$ 676,944
Investments, Net (Note 4)	-	4,633	401,956	-	406,589	-	406,589
Accounts Receivable, Net (Note 5)	370	9,194	100,435	-	109,999	(109,216)	783
Advances and Prepayments (Note 8)	167	2,456	1	872	3,496	(666)	2,830
Total Intragovernmental Assets	**19,490**	**360,163**	**770,298**	**47,077**	**1,197,028**	**(109,882)**	**1,087,146**
Other than Intragovernmental Assets							
Accounts Receivable, Net (Note 5)	-	15,333	23,120	40	38,493	-	38,493
Inventory and Related Property, Net (Note 6)	-	19,302	-	-	19,302	-	19,302
Property, Plant and Equipment, Net (Note 7)	2	8,954	311	-	9,267	-	9,267
Advances and Prepayments (Note 8)	-	27	1	18	46	-	46
Other Assets	-	420	-	-	420	-	420
Total Other than Intragovernmental Assets	**2**	**44,036**	**23,432**	**58**	**67,528**	**-**	**67,528**
Total Assets	**$ 19,492**	**$ 404,199**	**$ 793,730**	**$ 47,135**	**$ 1,264,556**	**$ (109,882)**	**$ 1,154,674**
Stewardship Land (Note 21)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 12	$ 700	$ 110,009	$ 32	$ 110,753	$ (109,214)	$ 1,539
Debt (Note 10)	-	487	604	-	1,091	-	1,091
Advances from Others and Deferred Revenue	-	1,108	-	-	1,108	(666)	442
Other Liabilities (Note 14)	2	1,605	-	31	1,638	(2)	1,636
Total Intragovernmental Liabilities	**14**	**3,900**	**110,613**	**63**	**114,590**	**(109,882)**	**4,708**
Other than Intragovernmental Liabilities							
Accounts Payable	19	1,450	163	-	1,632	-	1,632
Entitlement Benefits Due and Payable (Note 11)	-	52,765	88,832	-	141,597	-	141,597
Federal Employee Salary, Leave, and Benefits Payable (Note 12)	22	1,465	10	15	1,512	-	1,512
Pensions and Other Post-Employment Benefits Payable (Note 12)	3	21,126	-	-	21,129	-	21,129
Environmental and Disposal Liabilities	-	453	-	-	453	-	453
Advances from Others and Deferred Revenue	-	1,535	2,621	-	4,156	-	4,156
Other Liabilities:							
Accrued Liabilities (Note 13)	697	15,692	-	782	17,171	-	17,171
Contingencies and Commitments (Note 15)	-	13,937	1,050	-	14,987	-	14,987
Other Liabilities (Note 14)	-	1,388	3,227	16	4,631	-	4,631
Total Other than Intragovernmental Liabilities	**741**	**109,811**	**95,903**	**813**	**207,268**	**-**	**207,268**
Total Liabilities	**755**	**113,711**	**206,516**	**876**	**321,858**	**(109,882)**	**211,976**
Net Position							
Unexpended Appropriations – Funds from Dedicated Collections (Note 20)	-	3,351	260,565	-	263,916	-	263,916
Unexpended Appropriations – Funds from Other Than Dedicated Collections	18,595	255,195	-	46,205	319,995	-	319,995
Total Unexpended Appropriations	**18,595**	**258,546**	**260,565**	**46,205**	**583,911**	**-**	**583,911**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 20)	-	21,400	326,649	-	348,049	-	348,049
Cumulative Results of Operations – Funds from Other Than Dedicated Collections	142	10,542	-	54	10,738	-	10,738
Total Cumulative Results of Operations	**142**	**31,942**	**326,649**	**54**	**358,787**	**-**	**358,787**
Total Net Position	**18,737**	**290,488**	**587,214**	**46,259**	**942,698**	**-**	**942,698**
Total Liabilities and Net Position	**$ 19,492**	**$ 404,199**	**$ 793,730**	**$ 47,135**	**$ 1,264,556**	**$ (109,882)**	**$ 1,154,674**

Other Financial Information

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2024
(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra HHS Eliminations Cost ( )	Intra HHS Eliminations Revenue	Consolidated Totals
ACF	$ 17,014	$ -	$ -	$ 65,615	$ 82,629	$ (290)	$ 23	$ 82,362
ACL	3,002	-	-	-	3,002	(15)	4	2,991
AHRQ	-	374	-	-	374	(25)	11	360
ASPR	-	984	-	-	984	(34)	-	950
CDC	-	18,817	-	-	18,817	(514)	207	18,510
CMS	-	634,217	886,857	-	1,521,074	(495)	21	1,520,600
FDA	-	4,379	-	-	4,379	(358)	14	4,035
HRSA	-	14,463	-	-	14,463	(240)	10	14,233
IHS	-	8,428	-	-	8,428	(250)	284	8,462
NIH	-	47,704	-	-	47,704	(254)	1,005	48,455
OS	-	26,331	-	-	26,331	(885)	615	26,061
PSC	-	2,607	-	-	2,607	(101)	937	3,443
SAMHSA	-	8,887	-	-	8,887	(69)	39	8,857
Totals	**$ 20,016**	**$ 767,191**	**$ 886,857**	**$ 65,615**	**$ 1,739,679**	**$ (3,530)**	**$ 3,170**	**$ 1,739,319**

Gross Cost and Earned Revenue

For the Year Ended September 30, 2024
(in Millions)

Responsibility Segments	Intragovernmental Gross Cost Combined	Intragovernmental Gross Cost Eliminations	Intragovernmental Gross Cost Consolidated	Intragovernmental Less: Earned Revenue Combined	Intragovernmental Less: Earned Revenue Eliminations	Intragovernmental Less: Earned Revenue Consolidated	Other than Intragovernmental Gross Cost	Other than Intragovernmental Less: Earned Revenue	Consolidated Net Cost of Operations
ACF	$ 1,756	$ (290)	$ 1,466	$ (46)	$ 23	$ (23)	$ 80,938	$ (19)	$ 82,362
ACL	36	(15)	21	(5)	4	(1)	2,974	(3)	2,991
AHRQ	55	(25)	30	(13)	11	(2)	335	(3)	360
ASPR	126	(34)	92	(1)	-	(1)	859	-	950
CDC	1,640	(514)	1,126	(329)	207	(122)	17,658	(152)	18,510
CMS	1,463	(495)	968	(55)	21	(34)	1,683,545	(163,879)	1,520,600
FDA	2,002	(358)	1,644	(23)	14	(9)	5,603	(3,203)	4,035
HRSA	421	(240)	181	(10)	10	-	14,124	(72)	14,233
IHS	1,006	(250)	756	(327)	284	(43)	10,181	(2,432)	8,462
NIH	2,182	(254)	1,928	(1,147)	1,005	(142)	46,949	(280)	48,455
OS	4,956	(885)	4,071	(670)	615	(55)	22,064	(19)	26,061
PSC	544	(101)	443	(1,197)	937	(260)	3,262	(2)	3,443
SAMHSA	134	(69)	65	(75)	39	(36)	8,839	(11)	8,857
Totals	**$ 16,321**	**$ (3,530)**	**$ 12,791**	**$ (3,898)**	**$ 3,170**	**$ (728)**	**$ 1,897,331**	**$ (170,075)**	**$ 1,739,319**

Other Financial Information

Federal Entity Trading Partner Information

For the Year Ended September 30, 2024
(in Millions)

Reciprocal Category (RC)	Nature of Transactions	Balance	Federal Trading Partner
General Fund	Appropriations Used/Expended (RC 39/38)	$ 1,351,536	General Fund
	Appropriations received as adjusted (rescissions and other adjustments) (RC 41)	1,335,361	
	Fund Balance with Treasury (RC 40)	676,944	
	Other taxes and receipts (RC 45)	394,935	
	Non-entity collections transferred to the General Fund of the U.S. Government (RC 44)	2,964	
Investments	Federal investments (RC 01)	$ 403,993	Treasury
	Federal securities interest revenue including associated gains and losses (non-exchange) (RC 03)	11,811	
	Interest receivable – investments (RC 02)	2,596	
Buy/Sell	Buy/sell cost (RC 24)	$ 8,114	DoD, DOI, GSA
	Advances and prepayments (RC 23)	2,830	DOI
	Other liabilities – Reimbursable activities (RC 22)	1,221	Treasury
Transfers	Expenditure transfers-out of financing sources (RC 09)	$ 3,800	SSA
	Transfers payable (RC 27)	1,086	SSA, DOJ
Benefits	Benefit program costs (RC 26)	$ 2,787	OPM
Custodial	Collections transferred into a TAS Other Than the General Fund of the U.S. Government – Nonexchange (RC 15)	$ 1,186	DOJ
Borrowings	Loans payable (RC 17)	$ 1,091	Treasury
Imputed Costs	Imputed Costs/Imputed financing sources (RC 25)	$ 1,047	OPM

HHS has identified material transactions of $1.0 billion or greater at the end of the year with the above significant federal trading partners.

Summary of Financial Statement Audit and Management Assurances

As described in the "Management's Discussion and Analysis" section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to any material weakness identified during the audit, as well as conformance with the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) and compliance with the *Federal Financial Management Improvement Act of 1996* (FFMIA).

Table 1: Summary of Financial Statement Audit

Audit Opinion			Unmodified for Four Financial Statements and Disclaimed Opinion on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			No		
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
No Material Weaknesses Noted	0	-	-	-	0
Total Material Weaknesses	*0*				*0*

Definition of Terms – Tables 1 And 2

(Reference: Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements*, May 30, 2024, pages 109-110)

Beginning Balance: The beginning balance must agree with the ending balance from the prior year.

New: The total number of material weaknesses/non-conformances identified during the current year.

Resolved: The total number of material weaknesses/non-conformances that 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 finding does not meet the criteria for materiality or is redefined as more correctly classified under another heading).

Ending Balance: The year-end balance will be the beginning balance next year.

Table 2: Summary of Management Assurances

Effectiveness of Internal Control over Reporting (FMFIA Section 2)

Statement of Assurance	Unmodified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
No Material Weaknesses Noted	0	-	-	-	-	0
Total Material Weaknesses	*0*					*0*

Effectiveness of Internal Control over Operations and Compliance with Laws and Regulations (FMFIA Section 2)

Statement of Assurance	Modified					
Material Weaknesses/ Noncompliances	Beginning Balance	New	Resolved**	Consolidated	Reassessed	Ending Balance
Payment Integrity Information Act of 2019 (PIIA)*	2	-	1	0	-	1
Total Material Weaknesses/ Noncompliances	*2*		*1*	*0*		*1*

*The Department of Health and Human Services (HHS) identified material noncompliance with PIIA due to statutory limitations (Section 417 of the *Social Security Act*, 42 U.S.C. 617) preventing the Department from reporting an improper payment estimate for the Temporary Assistance for Needy Families (TANF).

**In FY 2024, HHS resolved material noncompliances with PIIA by (1) reporting an IP estimate for Foster Care and (2) reporting an IP estimate below the 10 percent statutory threshold for the Children's Health Insurance Program (CHIP).

Conformance with Federal Financial Management System Requirements (FMFIA Section 4)

Statement of Assurance	Federal Systems Conform to Financial Management System Requirements					
Noncompliance	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
No Noncompliance Noted	0	-	-	-	-	0
Total Noncompliance	*0*					*0*

Compliance with Section 803(a) of the FFMIA

	Agency	Auditor
1. Federal Financial Management System Requirements	No Lack of Substantial Compliance Noted	No Lack of Substantial Compliance Noted
2. Applicable Federal Accounting Standards	No Lack of Substantial Compliance Noted	No Lack of Substantial Compliance Noted
3. U.S. Standard General Ledger at Transaction Level	No Lack of Substantial Compliance Noted	No Lack of Substantial Compliance Noted

Civil Monetary Penalty Adjustment for Inflation

The *Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015* (the 2015 Act), as amended, requires agencies to make regular and consistent inflationary adjustments of civil monetary penalties to maintain their deterrent effect. To improve compliance with the 2015 Act, agencies are required to publish annual inflation adjustments in the Federal Register and should report annually in their Agency Financial Report.

The 2015 Act applies to eight Operating Divisions (OpDivs) and Staff Divisions (StaffDivs): Administration for Children and Families; Agency for Healthcare Research and Quality; Centers for Medicare & Medicaid Services; Food and Drug Administration; Health Resources and Service Administration; Office for Civil Rights; Office of the General Counsel; and Office of Inspector General. Refer to the Federal Register (unaudited) for the Annual Civil Monetary Penalties Inflation Adjustment for HHS.

Grants Closeout Reporting

To promote the efficient administration of HHS grants programs, all reporting entities must submit a brief high-level summary of expired, but not closed, federal grants and cooperative agreements (awards).

Table 1: HHS Expired-but-not-Closed Awards with a Period of Performance (POP) End Date Exceeding 2 Years

Category	2 3 Years FYs 2021 - 2022	3 5 Years FYs 2019 - 2021	More than 5 Years Before FY 2019
Number of Grants/Cooperative Agreements with Zero Dollar Balances	809	69	64
Number of Grants/Cooperative Agreements with Undisbursed Balances	1,430	711	441
Total Amount of Undisbursed Balances	**$2,554,371,823**	**$640,142,675**	**$264,861,157**

HHS continues to make grant closeout a priority by re-engineering business process improvements and enhancing grant systems to prevent the future growth of backlogs. When the number of grants and cooperative agreements reported in **Table 1** above are totaled, HHS has 3,524 grant awards with POP end dates of September 30, 2022 or earlier that are expired but not yet closed. Table 1 above is not comparable to previous HHS AFR *Grants Oversight and New Efficiency Act* reporting as the OMB Circular A-136, *Financial Reporting Requirements*, parameters were modified from before September 30, 2020, to the current requirement of September 30, 2022.

HHS remains committed to addressing and remediating the complexities that prevent the closeouts of open but expired accounts. During fiscal year (FY) 2024, HHS continued its focus on open grant documents with expired POP dates greater than 5 years, reflecting a 10% decrease (from 563 to 505) in these grant documents originally reported in the FY 2023 AFR. The increase in the remaining backlog is primarily due to expired amounts permitted under appropriations law and statutory authority, including COVID-19 awards with extended liquidation periods. HHS will continue its work into FY 2025 and utilize its Closeout Re-Engineering Council to improve the effectiveness and efficiency of the closeout process. The Closeout Re-Engineering Council is focusing on solutions in the areas of closeout policy, systems improvements, and enhanced training to support timely and accurate closeout of awards.

This year marks the 25th anniversary of the Supreme Court ruling of Olmstead v L.C. This historic decision affirmed the value of the lives and contributions of people with disabilities, recognized the importance of participation in the community for everyone, and heralded a change in the way our country approaches providing supports to disabled people of all ages. It has transformed the lives of countless people with disabilities.

Did You Know?

Payment Integrity Report

OVERVIEW

Payment integrity ensures that government payments are accurate, timely, and lawful. It involves preventing and detecting improper payments, including fraudulent payments, through verification, auditing, and accountability measures, ensuring funds are used effectively and according to legal guidelines.

An improper payment is any payment that does not meet legal requirements or is made in an incorrect amount. This includes payments made to ineligible recipients, for ineligible or duplicate goods or services, or for goods or services not received (unless authorized by law). It also includes unauthorized payments or payments made without considering applicable discounts. In contrast, an unknown payment lacks sufficient documentation to determine whether it is proper or improper. If a program is still reviewing a payment when it is time to report improper payment results, it is classified as an unknown payment for that year. In improper payment estimation, unknown payments are reported separately, but also combined with improper payments in the total improper plus unknown payment estimate. This ensures accountability and prevents potential fraud or misuse of funds by requiring proper documentation to verify the legitimacy of payments.

HHS is committed to reducing improper and unknown payments across programs, enhancing recipient services, and safeguarding taxpayer resources. The Department employs innovative solutions to address the root cause of improper payments while ensuring access to health and human services for beneficiaries.

HHS publishes detailed payment integrity information at PaymentAccuracy.gov. In accordance with the *Payment Integrity Information Act of 2019* (PIIA); OMB Circular A-136, *Financial Reporting Requirements*; and Appendix C of OMB Circular A-123, *Requirements for Payment Integrity Improvement* (M-21-19), HHS's Fiscal Year (FY) 2024 Payment Integrity Report also includes detailed information on:

Payment Integrity Topics	
1.0	**Risk-Susceptible Programs**
2.0	**Payment Categories**
3.0	**Financial Risk Management and Payment Integrity Assessment:**
3.1	**• Phase 1: Risk Assessments**
3.2	**• Phase 2: Improper Payment Estimation & Reporting**
4.0	**Mitigation Strategies & Corrective Actions:**
4.1	**• Payment Integrity Efforts**
5.0	**Proper, Improper, and Unknown Payments for Risk-Susceptible Programs:**
5.1	**• Improper and Unknown Payment Performance**
6.0	**Improper and Unknown Payment Error Types**
7.0	**Program-Specific Reporting Information:**
7.1	**• Medicare Fee-for-Service (FFS) (Parts A and B)**
7.2	**• Medicare Advantage (Part C)**
7.3	**• Medicare Prescription Drug Benefit (Part D)**
7.4	**• Medicaid**
7.5	**• Children's Health Insurance Program (CHIP)**
7.6	**• Advance Premium Tax Credit (APTC)**
7.7	**• Provider Relief Fund (PRF) Payments**
7.8	**• COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program (UIP)**
7.9	**• Temporary Assistance for Needy Families (TANF)**
7.10	**• Foster Care**
7.11	**• Child Care and Development Fund (CCDF)**
7.12	**• Head Start**
8.0	**Recovery Auditing Reporting**

1.0 RISK-SUSCEPTIBLE PROGRAMS

HHS conducts risk assessments of all its programs every three years to identify those that are susceptible to significant improper payments or unknown payments. A "significant" amount is defined by statutory thresholds, which apply if a program's annual amount of total improper and unknown payments meets either of the following:

1) 1.5 percent of program outlays and $10,000,000 in payments for the fiscal year, or
2) $100,000,000 regardless of the percentage of improper payments relative to total program outlays.

When a program meets either of those thresholds, it is classified as risk-susceptible and is required to estimate and report improper payments, reduction targets, and corrective actions.

Figure 1 provides a brief description of the programs that HHS or OMB identified as risk-susceptible and are discussed in this report.

Figure 1: Risk-Susceptible Programs

Medicare FFS*	A federal health insurance program for people aged 65 or older, people younger than 65 with certain disabilities, and people of all ages with End-Stage Renal Disease.
Medicare Part C*	A federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.
Medicare Part D*	A federal prescription drug benefit program for Medicare beneficiaries.
Medicaid*	A joint federal/state program, administered by the states, that provides health insurance to qualifying low-income individuals.
CHIP*	A joint federal/state program, administered by the states, that provides health insurance for qualifying children. In some states, CHIP covers pregnant women.
APTC*	A federal insurance affordability program, administered by HHS and the states, to support enrollees in purchasing Qualified Health Plan coverage from state and federal Health Insurance Exchanges (Exchanges).
PRF	A federal program that provided payments to eligible healthcare providers for healthcare related expenses or lost revenues attributable to COVID-19.
UIP	A federal program that provided claims reimbursement to healthcare providers for COVID-19 testing, treatment, and vaccine administration for uninsured individuals.
TANF	A joint federal/state program, administered by the states, that provides time-limited cash assistance as well as job preparation, work support, and other services to needy families with children to promote work, responsibility, and self-sufficiency.
Foster Care	A joint federal/state program, administered by the states, for children who are deemed to need placement outside their homes in a foster family home or a childcare facility.
CCDF	A joint federal/state program, administered by the states, that provides childcare financial assistance to working families with low income.
Head Start*	A federal program that provides comprehensive early learning and development, health, and family well-being services for eligible children ages birth to five and their families.

*OMB designates risk-susceptible programs as "high-priority" if their monetary loss estimates are over $100 million in a reporting year (RY). High-priority programs must fulfill additional requirements, including quarterly reporting on activities aimed at preventing and reducing improper payments, known as payment integrity scorecards, which are published under High-Priority Programs on PaymentAccuracy.gov. OMB designated these seven programs as high-priority programs for 2024.

2.0 PAYMENT CATEGORIES

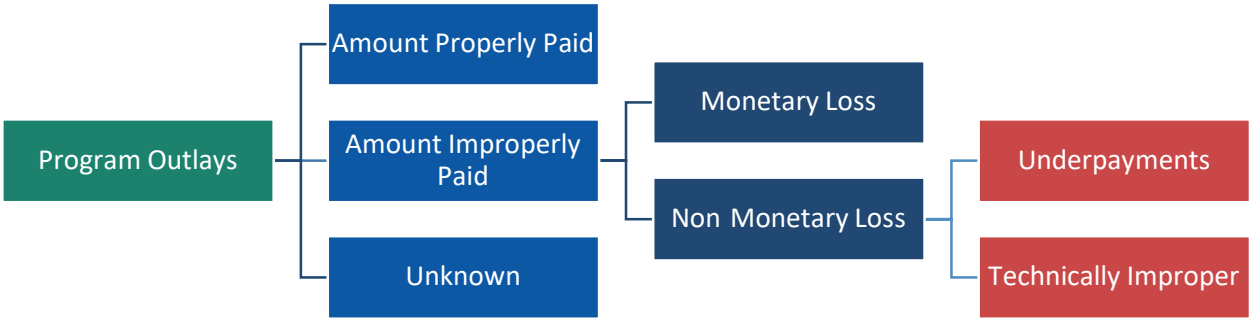
HHS estimates proper payments, improper payments, and unknown payments in its programs that are susceptible to significant improper payments. There are two types of improper payments:

1) **Monetary Loss:** Monetary loss is an overpayment. This is an amount that should not have been paid and is potentially recoverable.
2) **Non-monetary Loss:** Non-monetary loss can be an underpayment or technically improper payment, meaning a payment to the right recipient for the correct amount when the payment process did not comply with applicable regulations and statutes.

It is important to clarify that while all payments resulting from fraud are monetary loss improper payments, not all monetary loss improper payments result from fraud. Moreover, improper payment estimates are not fraud estimates.

Figure 2 illustrates payment categories and improper payment types.

Figure 2: Payment Categories



3.0 FINANCIAL RISK MANAGEMENT AND PAYMENT INTEGRITY ASSESSMENT

All programs with annual outlays greater than $10 million fall into either Phase 1 (subject to periodic risk assessments to determine susceptibility to significant improper payments) or Phase 2 (subject to statistical testing and reporting requirements), which require the varying degrees of oversight and effort described in the following subsections. Based on improper payment risk assessments, programs that are likely to have an annual amount of improper and unknown payments below the statutory threshold are categorized as Phase 1 and are required to complete a risk assessment once every three years. Programs likely to be above the statutory threshold are categorized as Phase 2 and are required to annually report an improper payment estimate and other information.

3.1 PHASE 1: RISK ASSESSMENTS

HHS reviews its programs using the Department's Risk Assessment Portal—an automated platform for collecting and processing risk assessments—to determine susceptibility to significant improper payments. This tool provides a comprehensive review and analysis of selected program operations, across a broad range of risk factors, to determine potential payment risks and risk severity. During FY 2024, to improve the improper payment risk assessment process, HHS updated the risk assessment questionnaire, the risk factor calculation, and Risk Assessment Portal. HHS continued to develop policies, procedures, and supporting tools throughout FY 2024, particularly to facilitate coverage of all programs over $10 million in accordance with PIIA. In addition, in FY 2024, HHS developed an online mechanism to track the inventory of programs subject to risk assessment.

In FY 2024, HHS conducted 89 program-specific improper payment risk assessments (a 59 percent increase from the prior year) and did not identify any additional programs that are susceptible to significant improper payments.

3.2 PHASE 2: IMPROPER PAYMENT ESTIMATION & REPORTING

All risk-susceptible programs, except for TANF, complied with OMB guidance on sampling and estimation plans and reported improper payment estimates. Because of statutory limitations that preclude HHS from requiring states to participate in a TANF improper payment measurement, TANF did not report an estimate.

Estimates for Medicaid, CHIP, Foster Care, and CCDF are based on a system of reviews wherein each state is reviewed triennially, and each year's improper payment estimate incorporates new review data for approximately one-third of states. As a result, the estimate is not based on the full population of payments for any one year but rather on a combination of statistical samples drawn from the last three consecutive years.

In FY 2024, HHS updated the sampling and estimation methodology plans for Medicare Part C, PRF, UIP, and Head Start. The statistical sampling and estimation processes—including any changes or updates in FY 2024—are detailed in Section 7.0: *Program-Specific Reporting Information*. A key objective of the sampling, estimation, and reporting process is to identify types of payment errors and provide data and insights that inform effective strategies to prevent future errors, allocate resources efficiently, and implement corrective actions to improve financial management.

4.0 MITIGATION STRATEGIES & CORRECTIVE ACTIONS

HHS is committed to improving payment integrity by preventing, reducing, and recovering improper payments. HHS monitors existing corrective actions and explores innovative approaches to reduce improper and unknown payments.

Each program creates mitigation strategies and corrective actions to address payment integrity risks, progressing through development, piloting, implementation, refinement, and completion. Programs with baseline measurements use these actions to set targets for reducing improper payments and timelines to achieve them. HHS annually reviews these strategies to ensure they address root causes and increase the likelihood of meeting targets and improving program integrity. If targets are not met, HHS develops new strategies, adjusts resources, and/or revises targets. Due to the varying nature of actions, establishing key milestones and completion dates can be challenging. For detailed mitigation strategies and corrective actions for each program, see Section 7.0: *Program-Specific Reporting Information*.

4.1 PAYMENT INTEGRITY EFFORTS

HHS strengthened payment integrity by collaborating with stakeholders on detection, enforcement, and investigations to prevent improper payments. Results of these cross-cutting efforts are outlined below.

Fraud Reduction

HHS adopts best practices in fraud risk management that align with PIIA and are based on GAO's *A Framework for Managing Fraud Risks in Federal Programs* (GAO-15-593SP, Fraud Risk Management Framework), the revised *Standards for Internal Control in the Federal Government* (Principle 8: Assess Fraud Risk, GAO-14-704G), and OMB Circular A-123 (*Management's Responsibility for Enterprise Risk Management and Internal Control*).

In FY 2022, HHS surveyed its Divisions and completed high-level fraud risk exposure assessments to establish a baseline for each Division's fraud risks and controls. HHS then applied its Fraud Risk Management Implementation Plan through FYs 2023 and 2024, with the Office of the Assistant Secretary for Financial Resources coordinating

the effort. This plan outlines HHS's phased approach to establishing a formal fraud risk management program. The Department's key activities include:

- Launching the Fraud Risk Assessment Portal (FRAP): This tool streamlines fraud risk assessments and generates actionable information for managers.
- Increasing Fraud Risk Assessments: In FY 2024, HHS completed fraud risk assessments for two additional programs, expanding these efforts after the tool's successful pilot in FY 2023.
- Enhancing the Fraud Risk Assessment methodology: HHS incorporated new fraud risk schemes and improved risk mapping.
- Developing the Fraud Risk Management Community of Practice: This platform serves as a central resource hub, facilitating over 50 fraud-related discussions since June 2023.
- Collaborating with the Chief Financial Officer Council's Payment Integrity Work Group: HHS shares strategies for government-wide fraud risk management.
- Conducting training sessions: HHS provided training to the Department's Financial Management community to foster a fraud-prevention culture. These sessions emphasized government-wide fraud risk management requirements, available resources, and HHS-specific initiatives, approaches, and tools.

HHS actively manages fraud risk through annual internal control reviews, audits, investigations of misuse, conflicts of interest, and misconduct. The Department monitors grant recipients through audit resolution, special conditions or drawdown restrictions, site visits, and performance reports. HHS also uses tools like the Do Not Pay (DNP) system, Grant Solutions' Recipient Data Insights, and SAM.gov to review potential and current recipients.

Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (the Partnership) is a voluntary public-private partnership that helps detect and prevent healthcare fraud through data and information sharing. Partners include federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations. The purpose of the Partnership is to help the partners improve capabilities to fight fraud, waste, and abuse across the healthcare sector. By the end of FY 2024, the Partnership grew to include 307 public, private, and state partner organizations.

Ninety-four partners submitted claim-level data, which a trusted-third party contractor analyzed for fraud, waste, and abuse. The contractor then provided organization-specific results to guide corrective actions. To foster collaboration, the Partnership continued to hold virtual information-sharing sessions and quarterly Executive Board meetings. These meetings aim to share known fraud schemes and provider alerts, provide non-privileged updates on law enforcement activities, and strategize ways to expand the Partnership's impact in both private and public sectors. In May 2024, the Partnership delivered a white paper, "Measuring the Value of Healthcare Anti-Fraud Efforts," providing Partners with a recommended approach to measuring the value and impact of their organization's fraud-fighting efforts. Additionally, the Partnership organized focus groups to guide the initiative's strategic direction.

Major Case Coordination

Since FY 2018, the Major Case Coordination initiative, involving the HHS Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), and HHS, has brought together Medicare and Medicaid policy experts, law enforcement officials, clinicians, and fraud investigators to collaborate on fraud leads. This initiative has substantially increased both the number and quality of law enforcement referrals from HHS, with ongoing program integrity efforts continuing to support investigations. In FY 2024, HHS reviewed 1,005 cases at Medicare Major Case Coordination meetings, and law enforcement partners made 465 requests for HHS to refer reviewed cases.

In FY 2020, HHS established the Medicaid Major Case Coordination process, bringing together HHS OIG, DOJ, state Medicaid Fraud Control Units, state program integrity units, and CMS to discuss Medicaid-related law enforcement referrals. In FY 2024, HHS reviewed 74 cases at Medicaid Major Case Coordination meetings, and law enforcement partners made 51 requests for HHS to refer reviewed cases from 18 different states. This process also helps identify Medicaid and CHIP vulnerabilities that can lead to improper payments.

Collaboration among these stakeholders supports coordinated law enforcement actions and helps HHS identify national trends and program vulnerabilities tied to fraud and improper payments. For more information on the Major Case Coordination initiative, please refer to the FY 2022 Health Care Fraud and Abuse Control Program Annual Report.

Medicaid Integrity Program

Under Section 1936 of the *Social Security Act* (the Act), as amended by the *Deficit Reduction Act of 2005* (DRA), HHS's Medicaid Integrity Program is responsible for:

- Reviewing Medicaid provider activities, auditing claims, identifying overpayments, and educating providers and others on Medicaid program integrity issues; and
- Supporting and assisting state efforts to combat Medicaid provider fraud, waste, and abuse.

The Medicaid Integrity Program includes federal personnel specialized in program integrity, as well as contractor support to states to bolster program integrity activities and collections. HHS's Medicaid recoveries demonstrate its continued commitment to Medicaid program integrity. Medicaid program integrity collections (federal and state shares) totaled $598.86 million in FY 2024.[27] In addition, HHS uses DRA funding to support critical Medicaid financial management oversight activities, including reviewing quarterly state expenditure requests to ensure appropriate use of federal funds, conducting targeted state financial management reviews based on questionable claims identified through claims review processes, and working with states to recover the federal share of unallowable Medicaid expenditures.

Medicaid Provider Enrollment

HHS provides ongoing guidance, education, and outreach to states on federal requirements for Medicaid provider screening and enrollment. HHS reviews Medicaid audit findings to identify policies that require further clarification and uses this information to update sub-regulatory guidance in the Medicaid Provider Enrollment Compendium.

HHS shares Medicare data to assist states and territories with meeting Medicaid screening and enrollment requirements. Since May 2016, HHS has offered a data compare service allowing states and territories to rely on Medicare's screening in lieu of conducting a state screening, particularly during revalidation. This allows states and territories to remove dually enrolled providers from the revalidation workload. HHS also returns information on providers who have deactivated National Provider Identifiers, are deceased, are excluded by the HHS OIG, or who are revoked by Medicare or terminated for cause by a State Medicaid Agency (thus allowing the state or territory to take deactivation or termination action against the provider when applicable). Using the data compare service, a state or territory provides a Medicaid provider enrollment data extract to HHS, then HHS returns information indicating which providers have undergone a Medicare screening, thereby reducing the state or territory's workload.

[27] This amount may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to finalizing state reporting.

Medicare Drug Integrity Contractors and Plan Sponsor Reporting

As part of HHS's ongoing efforts to ensure effective oversight of the Medicare Part C and Part D programs, HHS contracts with two Medicare Drug Integrity Contractors (MEDICs): 1) the Plan Program Integrity MEDIC (PPI-MEDIC) and 2) the Investigations MEDIC (I-MEDIC). The PPI MEDIC primarily assists HHS with audits of Part D drugs at high risk for improper payment, plan sponsor program integrity oversight operations, Part C and Part D plan sponsor education on emerging fraud schemes, and data analytics. The I-MEDIC conducts investigations of prescribers and pharmacies, recommends administrative actions, and submits case referrals to law enforcement.

As required under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act ("SUPPORT Act," Pub. L. No. 115-271), HHS developed the Health Plan Management System Program Integrity Portal for Fraud, Waste, and Abuse Reporting. This web-based portal allows plan sponsors to report fraud, waste, and abuse in the Medicare Part C and Part D programs and to share information among HHS, Medicare Part C and Part D plan sponsors, and the I-MEDIC to assist in combatting fraud, waste, and abuse. The information that must be reported includes payment suspensions based on credible allegations of fraud by pharmacies and information on inappropriate prescribing of opioids. Plan sponsors may also report other substantiated or potential activities of fraud, waste, and abuse.

Provider and Supplier Screening for New and Existing Medicare Providers and Suppliers

HHS uses three levels of provider and supplier enrollment risk-based screening: limited, moderate, and high. Providers and suppliers in the "limited" risk category undergo verification of licensure and a wide range of database checks to confirm compliance with all provider- or supplier-specific requirements. Providers and suppliers in the "moderate" risk category are subject to unannounced site visits in addition to all the requirements in the "limited" screening level. Providers and suppliers in the "high" risk category are subject to fingerprint-based criminal background checks for five percent or greater owners in addition to all requirements in the "limited" and "moderate" screening levels.

HHS revalidates all existing Medicare providers and suppliers on an ongoing basis to verify that only qualified providers and suppliers deliver healthcare items and services to Medicare beneficiaries. HHS's provider screening and enrollment initiatives have had a significant impact on removing ineligible providers and suppliers from the Medicare program. HHS manages over 2.9 million distinct Medicare enrollments through the Provider Enrollment, Chain, and Ownership System (PECOS).

Public Assistance Reporting Information System

The Public Assistance Reporting Information System provides state public assistance agencies in all 50 states, the District of Columbia, and Puerto Rico with matching data to verify program eligibility and to detect and deter improper payments in TANF, Medicaid, Workers' Compensation, childcare related programs, and the Supplemental Nutrition Assistance Program (SNAP). Provided to states at no cost, the system helps states strengthen program administration by allowing states to compare public assistance data between non-interoperable systems. Over the course of four quarterly matches (May 2023 to February 2024), states submitted over 322.53 million records for matching and received average match records of 2.42 million unique social security numbers each quarter.

State public assistance agencies realize cost savings in a variety of manners using this data. For example:

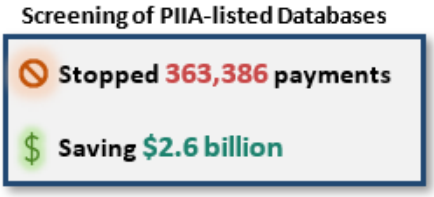
- The Connecticut Department of Social Services reported $1.95 million in cost avoidance for the 2023 calendar year;
- The New York's Office of Temporary and Disability Assistance closed or removed active clients from public assistance cases for projected cost savings of $55.92 million between April 2023 and March 2024;

- The Oregon Department of Human Services reported $22 million in annualized cost avoidance and reduced or closed 11,292 cases between July 2023 and June 2024;
- The Pennsylvania Department of Human Services reported $7.9 million in annualized cost avoidance in FY 2023; and
- The Washington State Health Care Authority's Veterans Program reported approximately $26.7 million in Medicaid cost savings from cessation of managed care premium payments and reduction in fee-for-service claims due to Third Party Liability discovery from data matches between July 2023 and June 2024.

For more information, refer to the Public Assistance Reporting Information System.

Results of the Do Not Pay Initiative in Preventing Improper Payments

Several Divisions use the government-wide DNP system to verify eligibility, either pre-payment to prevent improper payments or post-payment to identify overpayments. Further, U.S. Department of the Treasury (Treasury)-disbursed payments are matched against the Social Security Administration's Full Death Master File (DMF); Department of Defense Death Records; Department of State Death Records; Electronic Verification of Vital Events Fact of Death Data (contains information about death certificates from 43 participating states and jurisdictions); and American InfoSource Death Data[28] in the DNP portal daily to identify improper payments. The Department screened over 1.4 million payments against these death record databases, representing approximately $877 billion. The Department identified 74 payments over the past year through these daily matches for further investigation and HHS did not identify any as improper payments. CMS screened 1.0 billion payments against Treasury's DNP portal, representing $429.3 billion. Through these checks, CMS stopped 363,386 payments, representing a savings of $2.6 billion.



Single Audit Resolution

Non-federal entities that expended at least $750,000 in federal awards during their fiscal year were required to have an independent audit, known as a Single Audit, that includes testing of compliance with program requirements. Many HHS risk-susceptible programs (e.g., Medicaid, CHIP, CCDF, and Foster Care) are subject to Single Audit. During the Single Audit Resolution process, HHS works with recipients to ensure they take corrective action to address Single Audit findings.

Vulnerability Collaboration Council

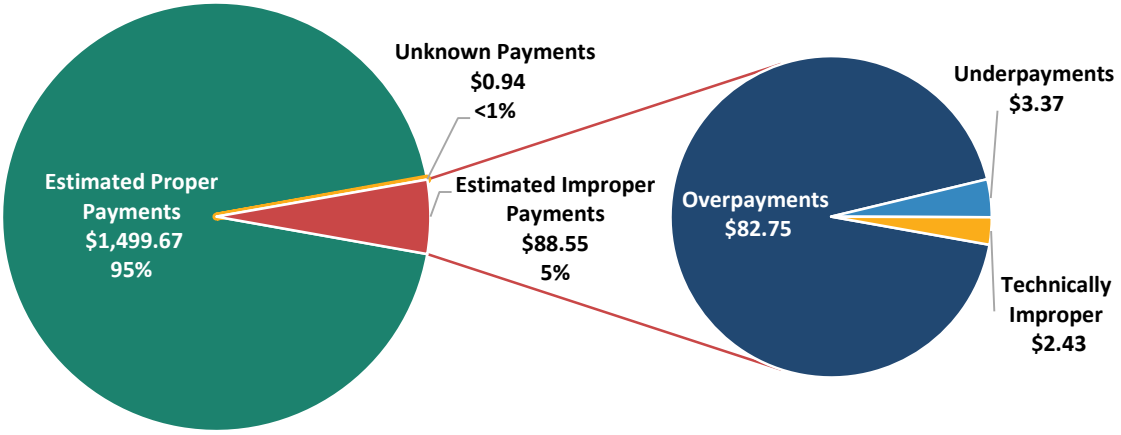
HHS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (the Council), is comprised of CMS leadership and subject matter experts that work collaboratively to identify and mitigate vulnerabilities in payment and coverage policies. HHS aligned the Council's risk-based approach with GAO's Fraud Risk Management Framework. In FY 2024, HHS conducted program integrity risk assessments, including completing risk assessments on durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and utilization management controls for nursing facilities and dental services for the Medicaid program. Additionally, HHS continued its work on potential vulnerabilities arising from COVID-19 waivers and flexibilities.

[28] A commercial data source that gathers information from funeral homes, newspapers, and county probate records.

5.0 PROPER, IMPROPER, AND UNKNOWN PAYMENTS FOR RISK-SUSCEPTIBLE PROGRAMS

Most of the Department's payments are proper, going to the right recipient for the right amount in compliance with legally applicable requirements. Under OMB's current guidance, unknown payments are defined and reported as a category separate from improper payments (see Section 2.0: *Payment Categories* for a description of unknown payments). **Figure 3** illustrates the overpayment, underpayment, unknown payment, and technically improper payment estimates for all of HHS's risk-susceptible programs.

Figure 3: RY 2024 Estimated Proper, Improper, and Unknown Payments[1] (Dollar Amounts in Billions)



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

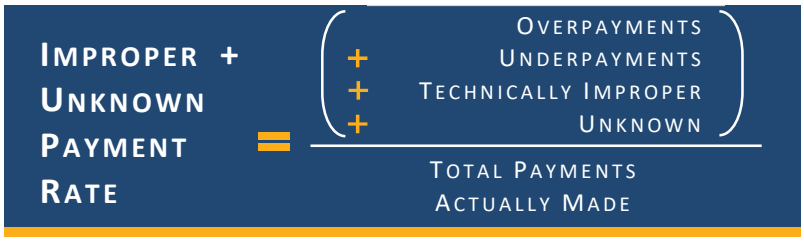
5.1 IMPROPER AND UNKNOWN PAYMENT PERFORMANCE

The latest estimates, reported below in **Table 1**, are referred to as the "RY 2024" estimates. These estimates are based on statistical samples from populations of payments made for or during a Review Period (RP) that differs from program to program and generally lags behind the Reporting Year (RY). **Table 1** displays the following, as applicable, for each risk-susceptible program:

- RY 2024 ("RY") data for each program's most recent RP:
  - Outlays (Total Payments Actually Made);
  - Estimated rate (%) and dollar amount ($) of:
    - Proper Payments (PP);
    - Improper Payments (IP);
    - Unknown Payments (UP); and
    - Improper Payments + Unknown Payments (IP + UP).
- RY 2025 ("RY+1") data:
  - Outlays—provisional data; and
  - Target rate (%) and amount ($) of Reduction Target.

Figure 4 provides the equation for calculating the improper plus unknown payment rate.

Figure 4: Improper Plus Unknown Payment Rate Equation



The improper plus unknown payment rate is the official program rate for payments that are not verifiably proper and is included in **Table 1**.

Table 1: HHS's Risk-Susceptible and High-Priority Programs' Improper Payment Results and Outlook

RY 2024 (in Millions)[1]

Program or Activity	RY Outlays $	RY PP %	RY PP $	RY IP + UP %	RY IP + UP $	RY IP %	RY IP $	RY UP %	RY UP $	RY+1 Est. Outlays $	RY+1 Reduction Target %	RY+1 Reduction Target $
Medicare FFS	$413,719.24 [a]	92.34%	$382,016.61	7.66%	$31,702.62	7.66% [b]	$31,702.62	0.00%	0.00	$457,976.20 [c]	7.46%	$34,165.02
Medicare Part C	$339,932.01 [d]	94.39%	$320,856.10	5.61%	$19,066.91	5.61%	$19,066.91	0.00%	$0.00	$541,902.00 [e]	5.95% [f]	32,243.17
Medicare Part D	$96,521.39 [g]	96.30%	$92,946.30	3.70%	$3,575.09	3.70%	$3,575.09	0.00%	$0.00	$150,146.00 [h]	3.91% [i]	$5,870.71
Medicaid	$610,833.37 [j]	94.91%	$579,734.23	5.09%	$31,099.13	5.09% [k]	$31,099.13	0.00%	$0.00	$559,930.39 [j]	5.29% [l]	$29,612.47
CHIP	$17,587.75 [m]	93.89%	$16,513.75	6.11%	$1,074.00	6.11% [n]	$1,074.00	0.00%	$0.00	$17,244.43 [m]	6.49% [l]	$1,118.68
APTC	$55,707.64 [o]	98.99%	$55,144.70	1.01%	$562.93	1.01% [p]	$562.93	0.00%	$0.00	$73,812.75 [o]	N/A [p]	N/A
PRF	$6,171.20 [q]	99.94%	$6,167.38	0.06%	$3.82	0.00%	$0.03	0.06%	$3.78	N/A [q]	N/A	N/A
UIP	$19,269.29 [r]	99.09%	$19,093.48	0.91%	$175.81	0.91%	$173.52	0.01%	$2.29	N/A [s]	N/A	N/A
TANF	$16,703.60 [t]	N/A	N/A	N/A	N/A	N/A [u]	N/A	N/A	N/A	$15,863.50 [t]	N/A	N/A
Foster Care	$1,293.00 [v]	95.18%	$1,230.68	4.82%	$62.32	4.82% [w]	$62.32	0.00%	$0.00	$1,294.00 [v]	N/A [w]	N/A
CCDF	$17,096.00 [x]	95.07%	$16,252.50	4.93%	$843.50	4.93%	$843.50	0.00%	$0.00	$20,255.00 [x]	4.91%	$994.11
Head Start	$11,041.60 [y]	88.02 %	$9,718.72	11.98%	$1,322.88	3.53%	$389.64	8.45%	$933.24	$12,170.00 [y]	7.34%	$893.31

[1] Totals do not necessarily equal the sum of the rounded components.

ACCOMPANYING NOTES FOR TABLE 1: HHS'S RISK-SUSCEPTIBLE AND HIGH-PRIORITY PROGRAMS' IMPROPER PAYMENT RESULTS AND OUTLOOK

a) Medicare FFS RY outlays are from the FY 2024 Medicare FFS Improper Payments Report (based on claims submitted from July 2022 – June 2023).

b) HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services provided should have been outpatient services. This adjustment factor reflects the difference between the inpatient hospital claims paid under Medicare Part A and what the payment would have been had the hospital claim been properly submitted as a Medicare Part B outpatient claim. Application of the adjustment factor decreased the overall improper payment rate by 0.25 percentage points to 7.66 percent or $31.7 billion. Additional adjustment factor information is on pages 166-167 of HHS's FY 2012 AFR.

c) Medicare FFS RY+1 outlays are based on the *FY 2025 President's Budget*.

d) Medicare Part C RY outlays reflect 2022 Part C payments, as reported in the FY 2024 Medicare Part C Payment Error Final Report.

e) Medicare Part C RY+1 outlays are based on the *FY 2025 President's Budget*.

f) HHS expects the RY 2025 rate to be statistically similar to the RY 2024 rate; however, HHS will continue to observe how the rate fluctuates over the next couple of years when setting RY+1 targets. For RY 2025, HHS establishes a relationship mid-way between the upper limit of the 95 percent confidence interval and the current year estimated error rate to provide a realistic outyear target.

g) Medicare Part D RY outlays reflect 2022 Part D payments, as reported in the FY 2024 Medicare Part D Payment Error Final Report.

h) Medicare Part D RY+1 outlays are based on the *FY 2025 President's Budget*.

i) HHS made methodology changes in RY 2023, and RY 2024 establishes a baseline for Medicare Part D. HHS expects the RY 2025 rate to be statistically similar to the RY 2024 rate; however, HHS will continue to observe how the rate fluctuates over the next couple of years when setting RY+1 targets. For RY 2025, HHS established a relationship mid-way between the upper limit of the 95 percent confidence interval and the current year estimated error rate to provide a realistic outyear target.

j) Medicaid RY outlays are based on FY 2023 expenditures, and RY+1 outlays (Medicaid – Outlays current law exclude Centers for Disease Control and Prevention (CDC) Vaccine for Children program funding) are based on the *FY 2025 President's Budget*.

k) HHS calculated and is reporting the national Medicaid estimates based on measurements conducted in FYs 2022, 2023, and 2024. The national Medicaid component improper payment estimates are Medicaid FFS: 4.83 percent, Medicaid managed care: 0.00 percent, and Medicaid eligibility: 3.31 percent.

l) Medicaid and CHIP targets are higher than reported rates due to a higher anticipated volume of eligibility redeterminations and provider screenings being performed by states subsequent to the end of the public health emergency. The target assumes a similar, but potentially slightly increased result by using the midpoint of the RY improper payment point estimate and the upper bound of the confidence interval.

m) CHIP RY outlays are based on FY 2023 expenditures, and RY+1 outlays are based on the *FY 2025 President's Budget*.

n) HHS calculated and is reporting the national CHIP estimates based on measurements conducted in FYs 2022, 2023, and 2024. The national CHIP component improper estimates are: CHIP FFS: 4.72 percent, CHIP managed care: 0.72 percent, and CHIP eligibility: 4.44 percent.

o) APTC RY outlays are for the Federally-facilitated Exchange only and are based on internal financial reporting.

p) The APTC improper payment results represents improper payments for the Federally-facilitated Exchange. HHS continues to develop the improper payment measurement methodology for the State-based Exchanges and will continue to update the AFR with the measurement program development status. The APTC program is not reporting a RY+1 improper payment target. The publication of a reduction target will occur once the State-based Exchanges are included in the measurement to establish and report a full baseline. See Section 7.6: *APTC* for more information.

q) Following the passage of the *Fiscal Responsibility Act* (FRA) in June 2023 and the related rescission of program funds, no further PRF payments will be issued.

r) UIP outlays are based on the *Families First Coronavirus Response Act* (*Pub. L. No. 116-127*); *Pub. L. No. 116-136*; *Pub. L. No. 116-139*; and *Pub. L. No. 117-2*. Please note the total outlays are for FY 2023 and FY 2024 UIP and are based upon adjusted claims payments during the period March 27, 2021 through March 26, 2023.

s) Following the passage of the FRA in June 2023 and the related rescission of program funds, no further UIP payments will be issued.

t) TANF RY and RY+1 outlays are based on the *FY 2025 President's Budget* baseline (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs and excluding the TANF Contingency Fund).

u) The TANF program is not reporting estimates for FY 2024. Statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement.

v) Foster Care RY and RY+1 outlays are based on the *FY 2025 President's Budget* baseline and reflect the federal share of maintenance payments.

w) HHS resumed conducting Title IV-E reviews in 2024 and is reporting an error rate for the Foster Care program in FY 2024 based on data from six states reviewed in FY 2024. HHS is not reporting a RY+1 improper payment plus unknown payment target for FY 2025 and will not set a target for improvement until all states have been newly reviewed and the program reestablishes a baseline.

x) CCDF RY and RY+1 outlays are based on the *FY 2025 President's Budget* baseline.

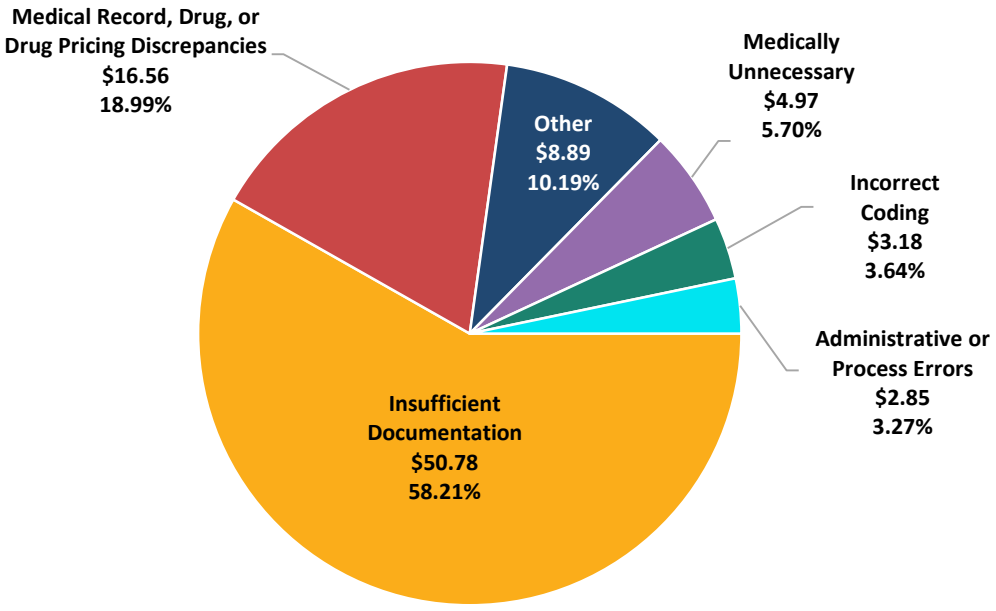
y) Head Start RY and RY+1 outlays are based on the *FY 2025 President's Budget* baseline.

6.0 IMPROPER AND UNKNOWN PAYMENT ERROR TYPES

Figure 5 below displays HHS's main payment error types for all risk-susceptible programs. Most error types are more detailed than OMB root cause categories to help generate useful information regarding HHS improper payments.

Section 7.0: *Program-Specific Reporting Information* provides additional information on error types, mitigation strategies, and corrective actions.

Figure 5: RY 2024 Improper and Unknown Payment Error Types for Risk-Susceptible Programs[1]
(Dollar Amounts in Billions)



[1] Input Errors and Incorrect Calculation each accounted for less than one percent of HHS's improper and unknown payments ($0.00003 billion and $0.17 billion, respectively) and, thus, were not included in Figure 5. In addition, due to rounding, amounts in this figure may not add up precisely to other tables in this document.

HHS's estimated improper payments are distributed between overpayments, underpayments, and technically improper for each program. Overpayments classify as monetary loss, whereas underpayments and technically improper are non-monetary loss. The total amount of overpayments also includes improper payments due to missing or insufficient documentation that do not necessarily represent monetary loss. **Table 2** below displays the risk-susceptible programs' estimated overpayments and underpayments. Most programs did not identify any technically improper payments for RY 2024. As a result, the technically improper payment estimates reported by Medicaid ($1,604.79 million or 0.26 percent of the program's total payments), CHIP ($51.81 million or 0.29 percent of the program's total payments), APTC ($408.56 million or 0.73 percent of the program's total payments), and Head Start ($364.73 million or 3.30 percent of the program's total payments) are excluded.

Table 2: Estimated Improper Payments by Program
RY 2024 (in Millions)

	Overpayments		Underpayments	
Program or Activity	Amount	Percent of Total Payments	Amount	Percent of Total Payments
Medicare FFS	$31,000.65	**7.49%**	$701.98	**0.17%**
Medicare Part C	$17,204.23	**5.06%**	$1,862.68	**0.55%**
Medicare Part D	$3,052.65	**3.16%**	$522.44	**0.54%**
Medicaid	$29,370.43	**4.81%**	$123.91	**0.02%**
CHIP	$1,019.73	**5.80%**	$2.46	**0.01%**
APTC	$154.38	**0.28%**	$0.00	**0.00%**
PRF	$0.00	**0.00%**	$0.03	**0.00%**
UIP	$92.14	**0.48%**	$81.38	**0.42%**
Foster Care	$61.16	**4.73%**	$1.16	**0.09%**
CCDF	$776.05	**4.54%**	$67.45	**0.39%**
Head Start	$15.72	**0.14%**	$9.19	**0.08%**
Total [1]	**$82,747.14**	**5.15%**	**$3,372.68**	**0.21%**

[1] Totals do not necessarily equal the sum of the rounded components.

7.0 PROGRAM-SPECIFIC REPORTING INFORMATION

In addition to descriptions in this section, please refer to PaymentAccuracy.gov for additional information on HHS's payment integrity efforts.

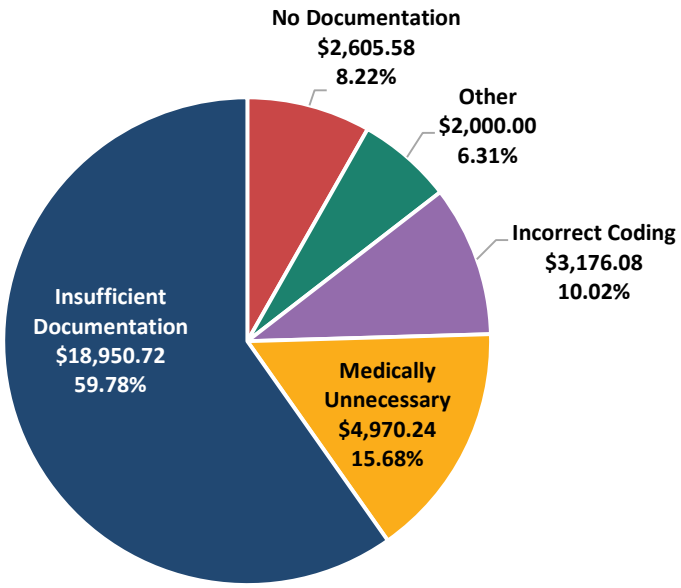
7.1 MEDICARE FFS (PARTS A AND B)

Medicare FFS Calculations and Findings

Medicare FFS paid an estimated 92.34 percent of total outlays properly, amounting to $382.02 billion. The estimated improper payments are 7.66 percent, or $31.70 billion. Improper payments due to missing or insufficient documentation accounted for 5.21 percent ($21.56 billion) of total outlays, representing 68.00 percent of all improper payments.

Figure 6 shows the estimated percentage and amount of improper payments associated with each error type.

Figure 6: RY 2024 Medicare FFS Estimated Payment Error Types[1] (Dollar Amounts in Millions)



[1] Figure may not equal 100 percent or add up precisely to other tables in this document due to rounding.

Improper payments for Skilled Nursing Facility (SNF), hospital outpatient, Inpatient Rehabilitation Facility (IRF), and hospice claims were major contributing factors to the Medicare FFS estimate, accounting for 38.88 percent of all improper payments. While the factors contributing to improper payments are complex and vary by year, the primary causes continue to be insufficient documentation and medically unnecessary errors as described in the following four driver service areas: [29]

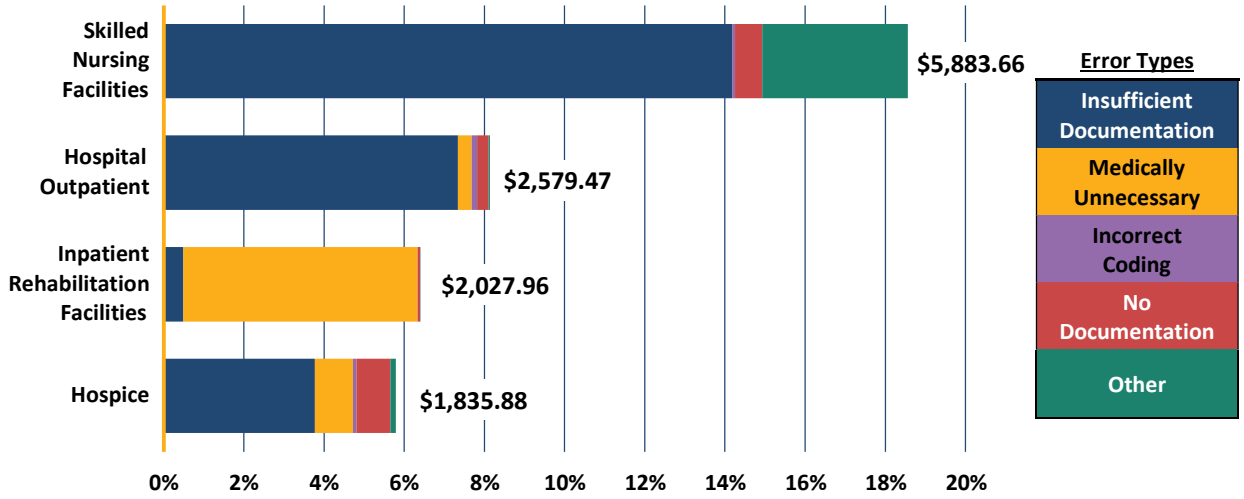
- **SNF:** Insufficient documentation continues to be the major error reason for SNF claims. The estimated improper payment rate for SNF claims increased from 13.76 percent in RY 2023 to 17.22 percent in RY 2024. The primary reasons for these errors are missing or insufficient documentation to support the SNF coverage criteria requirements (e.g., level of care requirements, certification/recertification) and missing or insufficient documentation to support the billed code.
- **Hospital Outpatient:** Insufficient documentation continues to be the major error reason for hospital outpatient claims. The estimated improper payment rate for hospital outpatient claims decreased from 5.20 percent in RY 2023 to 3.15 percent in RY 2024. The primary reasons for these errors are missing documentation to support the order for certain services and missing documentation to support medical necessity.
- **IRF:** The leading cause of errors in claims for IRF is that the service was not medically necessary. The estimated improper payment rate for IRF claims decreased from 27.33 percent in FY 2023 to 26.51 percent in FY 2024; however, this change is not statistically significant. These errors primarily occur because the documentation does not substantiate the beneficiary's need for intensive rehabilitation, need for close supervision by a rehabilitation physician, or sufficient stability to actively engage in intensive rehabilitation.

[29] Although increases and decreases are identified, some are not statistically significant. An increase or decrease estimated from a statistical sample is said to be "not statistically significant" if the estimate's margin of error is too wide to conclude that the improper payment rate is different from the previous year.

- **Hospice:** Insufficient documentation is the major error reason for hospice claims. The estimated improper payment rate for hospice claims increased from 5.36 percent in RY 2023 to 7.10 percent in RY 2024; however, this change is not statistically significant. The primary reason for these errors is missing or insufficient documentation to support the physician/provider certification or recertification.

Figure 7 shows the RY 2024 Medicare FFS drivers for SNF, hospital outpatient, IRF, and hospice claims by error type.

Figure 7: RY 2024 Medicare FFS Service Areas with the Largest Estimated IP+UP Dollar Amounts: Percentage Share of Medicare FFS IP+UP by Error Type (Dollar Amounts in Millions)



Statistical Sampling Process

HHS reviews a stratified random sample of Medicare FFS claims to determine if HHS properly paid claims under Medicare's policies on coverage, coding, and billing.

Figure 8 below depicts the sampling process.

Figure 8: Sampling Process

The sampling process ensures statistically valid random sampling across four claim types:

- Part A hospital Inpatient Prospective Payment System claims;
- Part A claims excluding hospital Inpatient Prospective Payment System (including but not limited to home health, IRF, SNF, and hospice);
- Part B claims (e.g., physician, laboratory, and ambulance services); and
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

For the RY 2024 estimates, HHS sampled approximately 50,000 claims representative of the Medicare FFS claims processed from July 1, 2022, through June 30, 2023. Additional information on the Medicare FFS improper payment methodology is on pages 166-167 of HHS's FY 2012 AFR.

Medicare FFS Mitigation Strategies and Corrective Actions

HHS employs a multifaceted approach to combat improper payments in Medicare FFS. This includes implementing corrective action plans and fostering interagency collaboration to address emerging risks. Additionally, HHS has devised preventative measures to address service areas at high-risk for improper payment like SNF, hospital outpatient, hospice, and home health, aiming to curb improper payments through targeted actions.

HHS mitigates improper payments in Medicare FFS through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Automated Edits:** Implement automated coding edits (e.g., National Correct Coding Initiative) to prevent improper payments and reduce reliance on costly medical reviews. Savings achieved through these edits are reported each fiscal year in the Medicare and Medicaid Integrity Programs Annual Report.
Training	• **Provider Compliance Tips:** Provide educational fact sheets to help providers prevent claim denials, covering common billing errors, denial reasons, and compliance standards.
Internal Process or Policy Change	• **Hospital Outpatient Prior Authorization:** Continued prior authorization for procedures like spinal neurostimulators, rhinoplasty, and others, to prevent improper payments. • **DMEPOS Prior Authorization:** Added new orthoses codes to the prior authorization list. Nationwide implementation began in August 2024. • **Ambulance Transport Prior Authorization:** Continued nationwide prior authorization for repetitive, scheduled non-emergent ambulance transport to prevent improper claims. • **Provider & Supplier Screening:** Conducted screenings and site visits for new and existing Medicare providers and suppliers resulting in denials, deactivations and revocations based on non-compliance findings. • **Medical Review Strategies:** Targeted reviews of high-risk claims (e.g., SNF, hospice, outpatient) using improper payment data to reduce documentation errors. • **Medical Review Accuracy Metric:** Improves accuracy and consistency in medical reviews across contractors, ensuring effective provider education and policy clarity. • **Review Choice Demonstration for IRF & Home Health Services:** Ongoing projects that allow providers pre- or post-payment review options, based on their compliance with Medicare rules, to reduce claim denials and improper payments. • **SNF 5-Claim Probe & Educate:** Assists SNFs in adapting to new billing models and lowering the improper payment rate. • **Hospice Program Integrity Strategy:** Strengthened the oversight of hospice programs through measures like the Provisional Period of Enhanced Oversight (PPEO) and claim reviews for new providers. • **Provider Billing Review Evaluation:** Used Comparative Billing Reports (CBRs) to highlight over-utilization trends among providers and support compliance with Medicare billing rules. The program was paused in FY 2023 but will resume in Fall 2024.
Audits	• **Targeted Probe & Educate:** Carried out multi-round audits for claims submitted by hospital outpatient, IRF, SNF, home health, hospice providers, and DMEPOS suppliers. The process includes education for providers after each review round. • **Supplemental Medical Review Contractor (SMRC) Reviews:** Conducted post-payment reviews of claims in high-risk areas, such as hospital outpatient services,

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	SNF, IRF, hospice, and DMEPOS. Results were shared with Medicare contractors for claim adjustments and overpayment recovery. • **Recovery Audit Contractor (RAC) Reviews:** Focused on identifying and recovering improper payments, particularly in hospital outpatient services, and professional services, with a significant percentage of recoveries coming from these areas.
Predictive Analytics	• **Fraud Prevention System Models:** Used advanced algorithms to detect potentially fraudulent claims, providers, and suppliers. The system contributed to opening new investigations and enforcement actions against providers and suppliers engaging in suspicious activities.

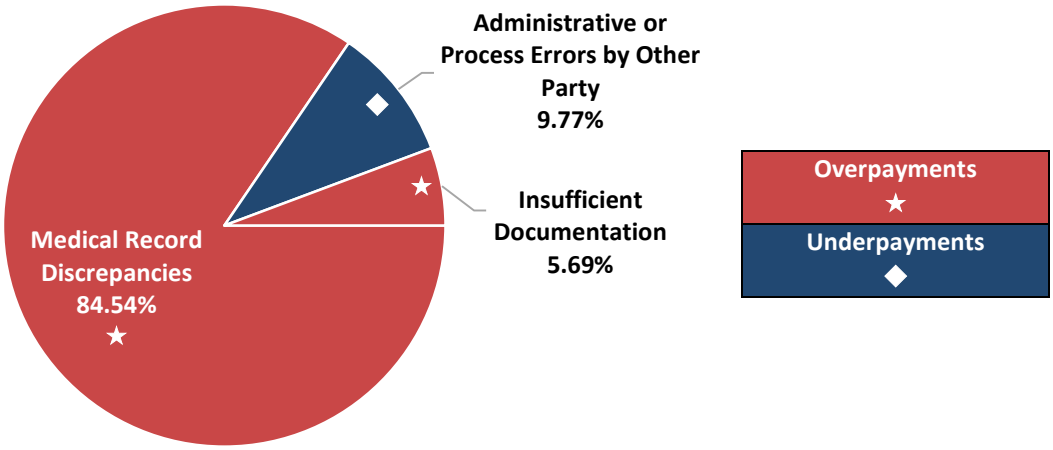
7.2 MEDICARE ADVANTAGE (PART C)

Medicare Advantage Calculations and Findings

Medicare Part C paid an estimated 94.39 percent of total outlays properly, amounting to $320.87 billion. The estimated improper payments are 5.61 percent, or $19.07 billion. Improper payments due to missing or insufficient documentation accounted for 0.32 percent ($1.09 billion) of total outlays, representing 5.69 percent of all improper payments.

The primary error type for Medicare Part C improper payments is medical record discrepancies, accounting for 84.54 percent of all improper payments. Improper payments due to medical record discrepancies occur when medical record documentation submitted by the Medicare Advantage Organization (MAO) does not substantiate a CMS Hierarchical Condition Category (CMS-HCC) for which the MAO received payment. The underpayment component derives from CMS-HCCs that (a) were not submitted by the MAO for payment but (b) are substantiated by the medical record review and (c) fall within the same hierarchy as a less-severe diagnosis that the MAO did submit for payment.[30] The breakdown of Medicare Part C improper payments is displayed in **Figure 9** below.

Figure 9: RY 2024 Medicare Part C Estimated Payment Error Types [1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

[30] Starting with RY 2022, the estimates have reflected a determination that no underpayment exists for a CMS-HCC identified by the medical record review if it has no hierarchical relationship to any diagnosis submitted by the MAO for payment.

Statistical Sampling Process

The payments that MAOs receive from HHS are risk-adjusted to reflect the expected level of healthcare costs for each beneficiary. In most beneficiary risk scores, the beneficiary's diagnoses—specifically the ones that fall within a CMS-HCC—are the primary component. Therefore, the improper payment estimate for Part C is an estimate of the improper payments that occur when MAOs assert diagnoses that they cannot substantiate. To calculate this estimate, HHS selects a random sample of enrollees with one or more CMS-HCCs[31] and requests medical records to support each condition.

The RY 2024 estimates are for the population of beneficiaries for whom HHS made a risk-adjusted payment to an MAO in CY 2022 based on one or more CMS-HCCs. Starting with RY 2024, HHS enhanced the representativeness of the sample by including beneficiaries with End Stage Renal Disease (ESRD) and beneficiaries with hospice months. Applying the technical refinements and following the prior methodology, the FY 2024 rate is comparable to the baseline established with the FY 2023 improper payment rate. **Figure 10** below depicts the measurement process.

Figure 10: Part C Improper Payment Measurement Process

Medicare Advantage Mitigation Strategies and Corrective Actions

HHS mitigates improper payments in Medicare Part C through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Comprehensive Fraud, Waste, and Abuse Training:** HHS hosts webinars and in-person sessions focused on Medicare Part C fraud schemes, prevention techniques, and compliance strategies. These trainings include collaboration between plan sponsors and law enforcement, providing practical guidance and facilitating the sharing of best practices to combat fraud, waste, and abuse. • **Outreach for Improper Payment Documentation:** HHS engaged with plan sponsors to address any incomplete or invalid medical documentation, and issuing Final Findings Reports with feedback, where applicable, to improve future collection of medical records and reduce improper payments.
Audits	• **Risk Adjustment Data Validation (RADV) Audits:** HHS conducts contract specific risk adjustment data validation (RADV) audits to confirm that the accuracy of enrollees' diagnoses submitted by MAOs are supported by medical record documentation. When unsupported diagnoses are identified, it could lead to HHS making overpayment determinations and recovering those overpayments. • **I-MEDIC Investigations:** The I-MEDIC conducts investigations, makes provider revocation recommendations, and refers cases to law enforcement and other regulatory bodies for further action.

[31] Starting with RY 2024, enrollees with any CMS-HCCs generated solely from providers on the CMS Preclusion List are excluded from the sample. The portion of the payment attributable to such CMS-HCCs is improper and will be reflected in the total Part C estimated improper payment rate.

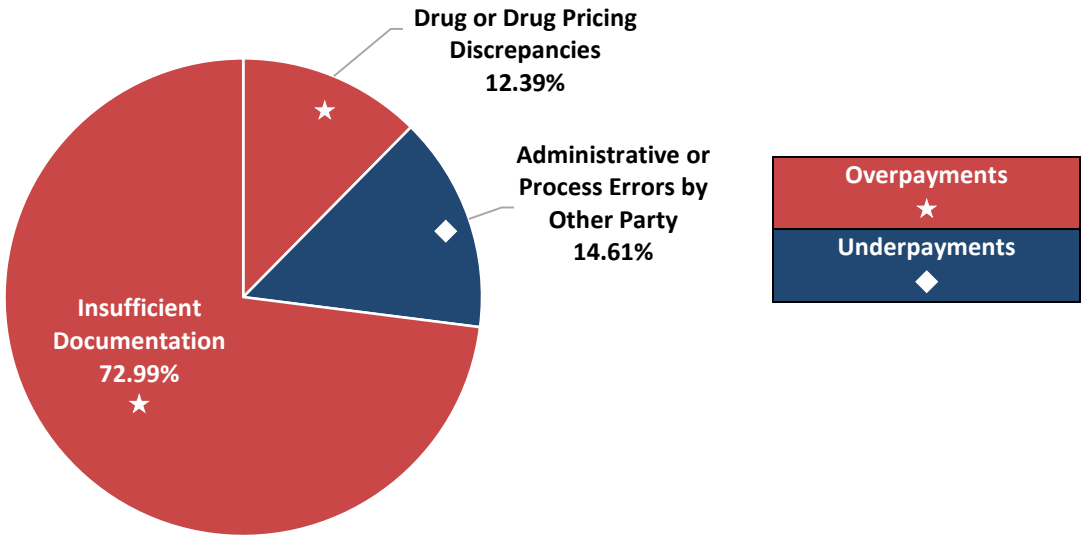
7.3 MEDICARE PRESCRIPTION DRUG BENEFIT (PART D)

Medicare Prescription Drug Benefit Calculations and Findings

Medicare Part D paid an estimated 96.30 percent of total outlays properly, or $92.95 billion. The estimated improper payments are 3.70 percent, or $3.58 billion. Improper payments due to missing or insufficient documentation accounted for 2.70 percent ($2.61 billion), representing 72.99 percent of all improper payments. The primary error type for Part D improper payments is missing documentation. RY 2024 serves as a baseline for improper payments in Medicare Part D, as the RY 2023 estimate reflects numerous methodology changes.

The breakdown of Medicare Part D improper payments is displayed in **Figure 11** below.

Figure 11: RY 2024 Medicare Part D Estimated Payment Error Types[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Statistical Sampling Process

The Part D improper payment measurement methodology estimates payment errors related to prescription drug event (PDE) data.[32] HHS measures inconsistencies between information reported on PDEs and the supporting documentation submitted by Part D sponsors, such as prescription record hardcopies (or medication orders as appropriate) and detailed claims information. Each sampled PDE is assigned a gross drug cost error based on these reviews. A representative sample of beneficiaries then undergoes a simulation to estimate their Part D improper payments by resampling gross drug cost errors from the PDE sample. HHS extrapolates those improper payments to the entire Part D population to produce the overall Part D improper payment estimate.

For RY 2023, HHS implemented several methodology changes,[33] and RY 2024 establishes a baseline. The RY 2024 error rate calculation follows previously implemented methodology changes. While the rates for RY 2024 and RY 2023 are comparable, they are not comparable to earlier reporting years.

[32] Prescription drug event (PDE) data represent the summary record of each time a beneficiary fills a prescription under Medicare Part D.
[33] FY 2023 methodology changes are described on pages 245-247 of HHS's FY 2023 AFR.

Medicare Prescription Drug Benefit Mitigation Strategies and Corrective Actions

HHS mitigates improper payments in Medicare Part D through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Comprehensive Fraud, Waste, and Abuse Training:** HHS hosts webinars and in-person sessions focused on Medicare Part D fraud schemes, prevention techniques, and compliance strategies. These trainings include collaboration between plan sponsors and law enforcement, providing practical guidance and facilitating the sharing of best practices to combat fraud, waste, and abuse. • **Outreach for Improper Payment Documentation:** HHS engaged with plan sponsors to address any incomplete or invalid medical documentation, and issuing Final Findings Reports with feedback, where applicable, to improve future collection of medical records and reduce improper payments.
Audits	• **Part D Prescription Drug Audits:** HHS conducts audits on Part D plan sponsors targeting drugs at a high-risk of improper payments. In the first three quarters of FY 2024, approximately $56.44 million was recovered from these audits.[34] • **I-MEDIC Investigations:** The I-MEDIC conducts investigations, makes provider revocation recommendations, and refers cases to law enforcement and other regulatory bodies for further action. • **Program Integrity Audits:** HHS performs Program Integrity audits to detect non-compliance and educate plan sponsors on fraud, waste, and abuse issues, further reducing improper payments. HHS performed four audits in FY 2024.

7.4 MEDICAID

Medicaid Calculations and Findings

Medicaid paid an estimated 94.91 percent of total outlays properly, amounting to $579.73 billion. The national Medicaid estimated improper payments are 5.09 percent, or $31.10 billion. (This estimate combines the results of all states' Medicaid FFS, Managed Care (MC), and eligibility components, with a correction factor so that payments that are improper in more than one of those components are not double counted.) Improper payments due to missing or insufficient documentation and technically improper payments accounted for 4.03 percent ($24.60 billion) of total outlays, representing 79.11 percent of all improper payments.

The national Medicaid improper payment estimate for each component is:

- *Medicaid FFS (based on errors identified in medical and data processing reviews)*: 4.83 percent of Medicaid FFS outlays;
- *Medicaid MC (based on errors identified in data processing reviews)*: 0.00 percent of Medicaid MC outlays; and
- *Medicaid eligibility (based on errors identified in eligibility reviews)*: 3.31 percent of all Medicaid outlays.

The decrease in the national Medicaid improper payment estimate can be attributed to two main factors. First it is the result of improved state compliance with program rules. Second, it is due to reviews that considered certain flexibilities given to states related to COVID-19, such as suspending eligibility determinations and reducing requirements for provider enrollment and revalidations, which were previously part of the improper payment

[34] HHS will report the full fiscal year recoveries from the PPI-MEDIC's national audits and Part D plan sponsor self-audits in the forthcoming Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

reviews prior to COVID-19. HHS will publish supplemental information related to the Medicaid results on the CMS website following AFR publication.

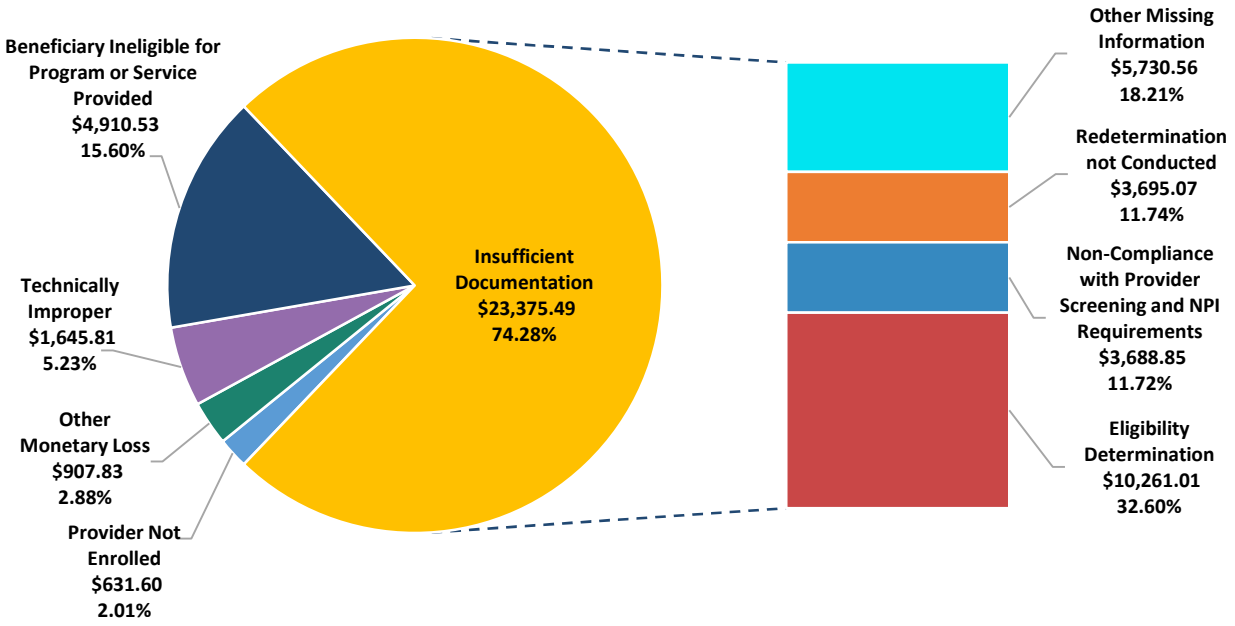
The areas driving the Medicaid improper payment estimate are:

- **Insufficient Documentation:** States failed to provide documentation that required verifications of eligibility, such as income verifications, were completed; or medical records were not submitted or were missing required documentation to support the medical necessity of the claim.
    - For RY 2024, HHS worked with states to independently verify certain situations where the state could not provide documentation to support state actions. This process included HHS independently accessing databases and reviewing submitted eligibility determination information that had been produced after the original claim payment or determination date to evaluate if a provider or beneficiary would have been eligible. Of the 277 claims eligible for independent verification, HHS independently verified 156. Of these 156 claims, HHS deemed all 156 claims as technically improper (i.e., the payment was to the right recipient for the correct amount, but the payment process did not comply with applicable regulations and statutes).
- **State Non-Compliance:** States did not comply with federal eligibility redetermination requirements; did not appropriately screen enrolled providers; paid providers that were not enrolled; or paid claims that lacked the required National Provider Identifier.

Despite independent verification efforts, a majority of Medicaid improper payments were still due to instances where information required for payment was missing, an eligibility determination was missing from the state system, states did not follow the appropriate process for enrolling providers, and/or states did not follow the appropriate process for determining beneficiary eligibility. These improper payments do not necessarily represent payments to ineligible providers or on behalf of ineligible beneficiaries. Had the missing information been on the claim or had the state complied with the enrollment or redetermination requirements, the claims may have been payable. Conversely, had the missing documentation been available, it could have affirmatively indicated that a provider or beneficiary was ineligible and the payment improper.

Figure 12 below provides a breakdown of Medicaid's payment error types, including: provider not enrolled; beneficiary ineligible for program or good/service; insufficient documentation; technically improper; and other Monetary Loss errors like medical and claims processing errors for incorrect coding, duplicate claims, or pricing mistakes. The insufficient documentation errors include claims where information was missing, or states did not follow appropriate processes to determine if a payment was proper or improper.

Figure 12: RY 2024 Medicaid Estimated Improper Payments by Error Types[1] (Dollar Amounts in Millions)

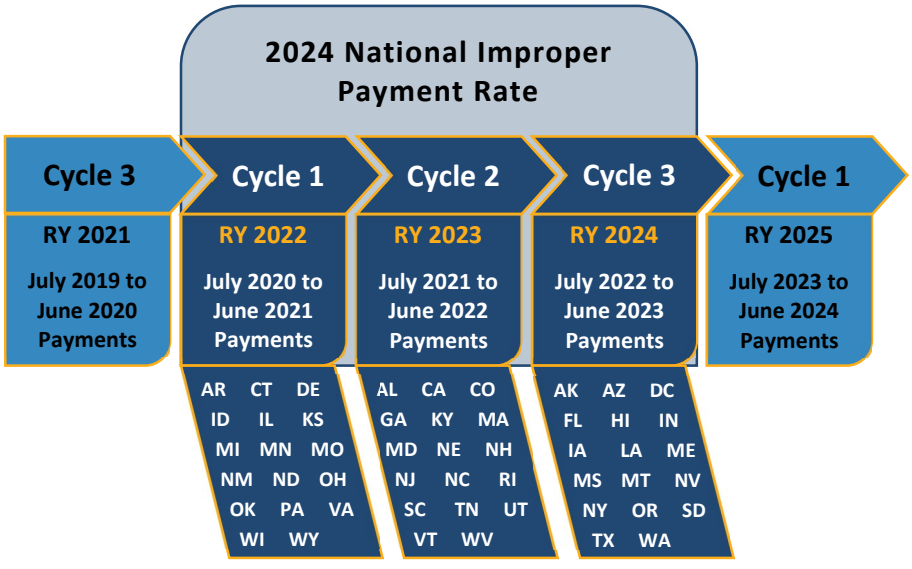


[1] The total Medicaid improper payments in Figure 12 are greater than the improper payment totals displayed in Table 1 and Table 2 because improper payments in this figure can be categorized in more than one payment error type. In addition, the figure may not equal or add up precisely to other tables in this document due to rounding.

Statistical Sampling Process

HHS estimates Medicaid improper payments on an annual basis through the Payment Error Rate Measurement (PERM) program, utilizing federal contractors to measure three components: FFS claims, Managed Care capitation payments, and eligibility determinations. HHS uses a 17-states-per-year, 3-year rotation. Each time a group of 17 states is measured, HHS removes that group's previous findings from the calculation and includes its newest findings. The RY 2024 national Medicaid rate is based on measurements from RYs 2022, 2023, and 2024 as seen in **Figure 13**.

Figure 13: RY 2024 Medicaid Cycle Measurements



To learn how HHS grouped states into three cycles, refer to pages 177-179 of HHS's FY 2012 AFR.

FFS and MC Components

FFS includes the traditional method of paying for medical services under which a state pays providers for each service rendered to individual beneficiaries. Under a MC delivery system, a state makes a periodic (usually monthly) capitation payment to a MC plan,[35] which is responsible for managing beneficiary care and paying providers. States submit adjudicated claims data quarterly and HHS randomly selects a sample of FFS claims and MC payments. Each selected FFS claim undergoes a medical and data processing review, whereas MC capitation payments undergo only a data processing review and not a medical review because the payment does not depend on what medical services were rendered. Therefore, full-risk and partial-risk payments to MC plans are reviewed as MC capitation payments, whereas non-risk payments to MC plans are reviewed and reported as FFS payments, as they are considered direct reimbursement for services rendered. Additionally, HHS selects a combination of FFS claims and MC payments for eligibility review.

Based on each state's expenditures and historical improper payment data for FFS and MC, the FFS sample size was between 288 and 1,782 claims per state, the MC sample size was between 38 and 200 payments per state, the eligibility FFS sample size was between 97 and 534 per state, and the eligibility MC sample size was between 97 and 644 per state.

Eligibility Component

Through the eligibility component, a federal contractor assesses the state's application of federal rules and documented state policies and procedures related to beneficiary eligibility. States must produce records and documentation to support the eligibility determination. Examples of noncompliance with eligibility requirements include a state: enrolling an ineligible beneficiary; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible good/service or incorrect federal reimbursement amount being provided; not conducting beneficiary redeterminations timely or at all; or not performing, completing, or providing sufficient documentation to support a required element of the eligibility determination process, such as income verification. See additional information regarding the eligibility component and establishment of a baseline measurement on pages 225-226 of HHS's FY 2021 AFR.

Medicaid Mitigation Strategies and Corrective Actions

Medicaid is a federal-state partnership, and HHS collaborates closely with all states to develop strategies to address root causes of improper payments. Each state is responsible for carrying out, overseeing, and assessing the impact of these strategies and actions. State efforts concentrate on making system or process improvements to decrease errors, such as introducing new claims processing checks, upgrading to an advanced claims processing system, enhancing provider enrollment procedures, improving beneficiary enrollment and redetermination processes, and enhancing provider communication and education to minimize errors related to documentation requirements.

HHS mitigates improper payments in Medicaid through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Medicaid Integrity Institute:** HHS provides training and support to state Medicaid program integrity officials through the Medicaid Integrity Institute, offering courses on provider auditing, fraud prevention, and more. In FY 2024, five in-person courses and six webinars were delivered.

[35] Includes managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management entities as defined in 42 CFR 438.2.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Internal Process or Policy Change	• **State Corrective Action Plan (CAP) Process:** HHS collaborates with states to implement effective Corrective Action Plans (CAPs) addressing identified errors. States receive enhanced technical assistance, guidance, and training to ensure compliance with federal policies. In 2024, HHS provided quarterly training sessions on root cause identification and CAP requirements.
Cross Enterprise Sharing	• **State Medicaid Provider Screening and Enrollment:** In FY 2024, 7 states—AK, MS, ND, NH, NV, NY, and VA—participated in the data compare service to improve Medicaid provider screening. • **Death Master File (DMF) Access**: To address state cost concerns in performing the Social Security Administration's DMF check during provider screening, HHS collaborated with the Social Security Administration to supply states with DMF data. Subsequently, HHS improved states' access to DMF data via the Data Exchange, a system for sharing data between HHS and state Medicaid programs. All 50 states, the District of Columbia, and Puerto Rico now have access to DMF data through the Data Exchange. • **Transformed Medicaid Statistical Information System (T-MSIS):** HHS enhanced Medicaid claims data submissions via T-MSIS, improving data quality and enabling real-time assessments. The system supports program integrity efforts, risk identification, audits, and overpayment recoveries.
Audits	• **Medicaid Eligibility Quality Control (MEQC) Program:** MEQC allows states to conduct pilot projects aimed at improving Medicaid and CHIP eligibility determinations. These reviews focus on error-prone areas and occur during the "off-years" between PERM reviews. • **Beneficiary Eligibility Audits:** In FY 2024, HHS conducted eligibility audits in states identified as high risk based on disenrollment rates during the unwinding period, focusing on eligibility determination processes based on monthly reporting metrics. • **Unified Program Integrity Contractors (UPICs):** UPICs conduct audits and investigations to combat fraud, waste, and abuse in Medicare and Medicaid. Audits and investigations target managed care providers and plans, covering hospitals, clinics, pharmacies, and more.

7.5 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP Calculations and Findings

CHIP paid an estimated 93.89 percent of total outlays properly, amounting to $16.51 billion. The national CHIP estimated improper payments are 6.11 percent, or $1.07 billion. This estimate combines the results of all states' CHIP FFS, MC, and eligibility components, with a correction factor so that payments that are improper in more than one of those components are not double counted. Improper payments due to missing or insufficient documentation accounted for 3.76 percent ($0.66 billion), representing 61.56 percent of all improper payments.

The national CHIP improper payment estimate for each component is:

- *CHIP FFS (based on errors identified in medical and data processing reviews)*: 4.72 percent of CHIP FFS outlays;
- *CHIP MC (based on errors identified in data processing reviews)*: 0.72 percent of CHIP MC outlays; and
- *CHIP eligibility (based on errors identified in eligibility reviews)*: 4.44 percent of all CHIP outlays.

The decrease in the national CHIP improper payment estimate can be attributed to two main factors. First, it is a result of improved state compliance with program rules. Second, it is due to reviews that considered certain flexibilities given to states related to COVID-19, such as suspending eligibility determinations and reducing requirements for provider enrollment and revalidations, which were previously part of the improper payment reviews. HHS will publish supplemental information related to the CHIP results on the Payment Error Rate Measurement page of the CMS website following AFR publication.

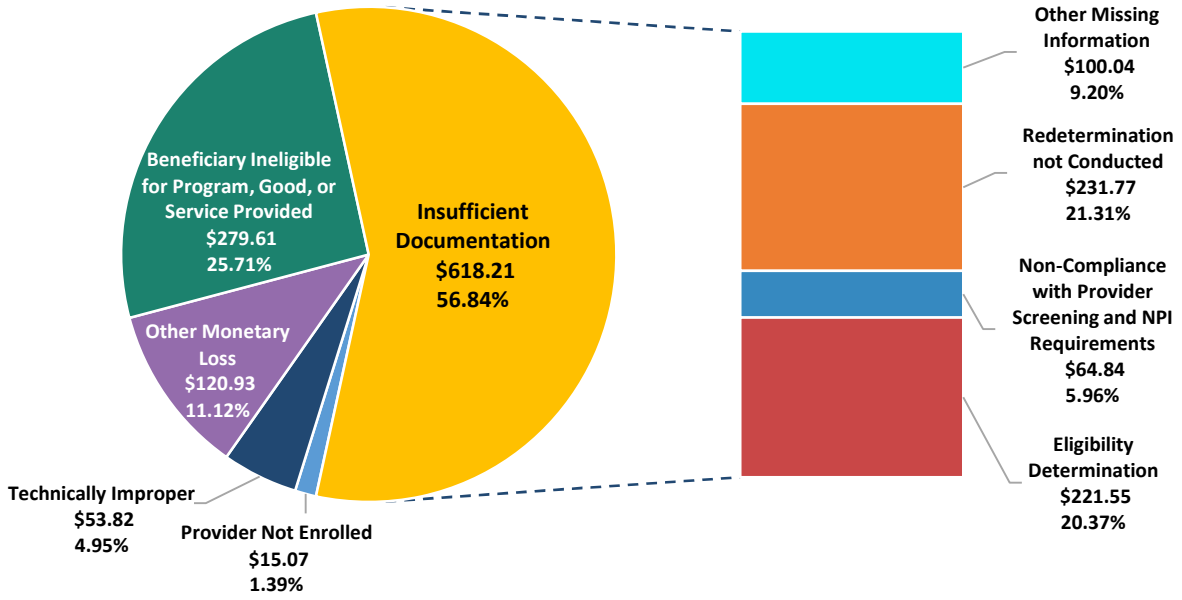
The areas driving the CHIP improper payment estimate are:

- **Insufficient Documentation:** States failed to provide documentation that required verifications of eligibility were completed, such as income verifications; or medical records were not submitted or were missing required documentation to support the medical necessity of the claim.
    - For RY 2024, HHS worked with states to independently verify certain situations where the state could not provide documentation to support state actions. This process included independently accessing databases and reviewing submitted eligibility determination information that had been produced after the original claim payment or determination date to evaluate if a provider or beneficiary would have been eligible. Of the 425 claims eligible for independent verification, HHS independently verified 369. Of these 369 claims, HHS deemed all 369 claims as technically improper (i.e., the payment was to the right recipient for the correct amount, but the payment process did not comply with applicable regulations and statutes).
- **State Non-Compliance:** States did not comply with federal eligibility redetermination requirements; did not appropriately screen enrolled providers; paid providers that were not enrolled; or paid claims that lacked the required National Provider Identifier.
- **Improper Determinations:** States inappropriately claimed beneficiaries under Title XXI (CHIP) rather than Title XIX (Medicaid), mostly related to incorrect state calculations based on beneficiary income, the presence of third-party insurance, household composition, or tax filer status. Improper determinations accounted for approximately 18.19 percent or $0.15 billion of total errors cited in CHIP eligibility.

Despite independent verification efforts, a majority of CHIP improper payments were still due to instances where information required for payment was missing, an eligibility determination was missing from the state system, states did not follow the appropriate process for enrolling providers, and/or states did not follow the appropriate process for determining beneficiary eligibility. These payments do not necessarily represent payments to ineligible providers or on behalf of ineligible beneficiaries. Had the missing information been on the claim or had the state complied with the enrollment or redetermination requirements, the claims may have been payable. Conversely, had the missing documentation been available, it could have affirmatively indicated that a provider or beneficiary was ineligible and the payment improper.

Figure 14 below illustrates the breakdown of CHIP's payment error types, including: provider not enrolled; beneficiary ineligible for program or good/service; insufficient documentation; technically improper; and other monetary loss errors like medical and claims processing errors for incorrect coding, duplicate claims, or pricing mistakes. The insufficient documentation errors include claims where information was missing, or states did not follow processes to determine if a payment was proper or improper.

Figure 14: RY 2024 CHIP Estimated Improper Payments by Error Types[1] (Dollar Amounts in Millions)



[1] The total CHIP improper payments in Figure 14 are greater than the improper payment totals displayed in Table 1 and Table 2 because improper payments in this figure can be categorized in more than one payment error type. In addition, the figure may not equal or add up precisely to other tables in this document due to rounding.

Statistical Sampling Process

HHS estimates CHIP improper payments on an annual basis through the PERM program, utilizing federal contractors to measure three components: FFS claims, MC payments, and eligibility determinations.

For CHIP, PERM uses the same state sampling process and the same three cycles of states as for Medicaid. For information on how HHS grouped states into three cycles for CHIP, refer to pages 183-185 of HHS's FY 2012 AFR. The RY 2024 national CHIP rate is based on measurements from RYs 2022, 2023, and 2024.

FFS and Managed Care Components

For CHIP, PERM uses the same general approach to the FFS and MC components as for Medicaid. See Section 7.4: *Medicaid*.

Based on each state's expenditures and historical improper payment data for FFS and MC, the FFS sample size was between 80 and 1,080 claims per state, the MC sample size was between 36 and 48 payments per state, the eligibility FFS sample size was between 40 and 368 per state, and the eligibility MC sample size was between 58 and 523 per state.

Eligibility Component

Through the eligibility component, a federal contractor assesses the state's application of federal rules and documented state policies and procedures related to beneficiary eligibility. States must produce records and documentation to support the eligibility determination. Examples of noncompliance with eligibility requirements include a state: inappropriately claiming a beneficiary under Title XXI (CHIP) rather than Title XIX (Medicaid); enrolling an ineligible beneficiary; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible good/service or incorrect federal reimbursement amount being provided; not conducting beneficiary redeterminations timely or at all; or not performing, completing, or providing sufficient documentation

to support a required element of the eligibility determination process, such as income verification. See additional information regarding the eligibility component and establishment of a baseline measurement on pages 230-231 of HHS's FY 2021 AFR.

CHIP Mitigation Strategies and Corrective Actions

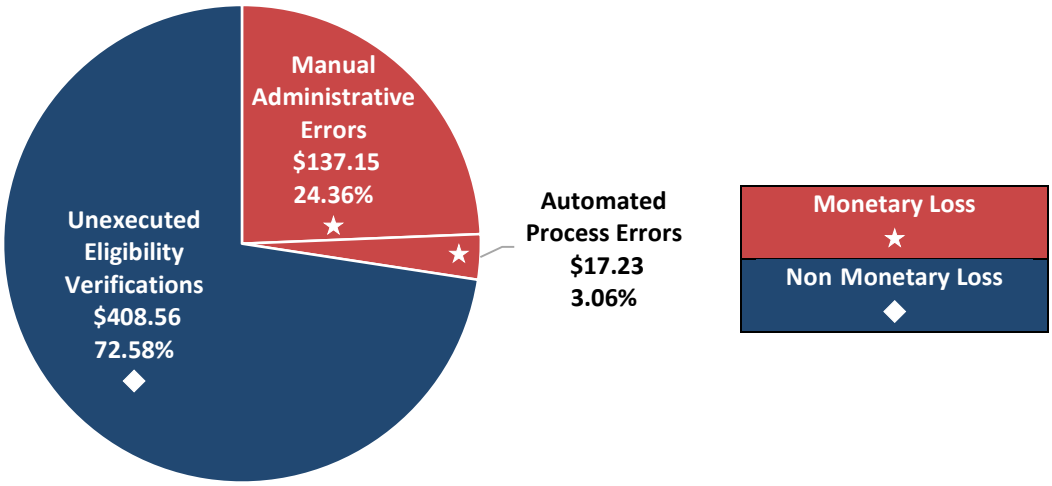
As CHIP is a federal-state partnership, HHS collaborates closely with all states to develop strategies to address root causes of improper payments. Each state is responsible for carrying out, overseeing, and assessing the impact of these strategies and actions. Many of the actions that states implement to address Medicaid improper payments, as outlined in Section 7.4: *Medicaid*, are also applicable to CHIP.

7.6 Advance Premium Tax Credit (APTC)

APTC Calculations and Findings

The Federally-facilitated Exchange (FFE) paid an estimated 98.99 percent of total outlays properly, amounting to $55.14 billion. The estimated improper payments are 1.01 percent, or $562.93 million. Technically improper payments accounted for 0.73 percent ($408.56 million) of total outlays, representing 72.58 percent of all improper payments. For RY 2024, technically improper payments are associated with cases where the FFE failed to conduct required periodic eligibility verifications, but HHS's review verified that the consumer maintained eligibility. Excluding technically improper payments, the improper payment rate is 0.28 percent ($154.38 million in overpayments), accounting for 27.42 percent of all improper payments. **Figure 15** below provides a breakdown of the APTC improper payment estimate.

Figure 15: RY 2024 APTC Estimated Payment Error Types (Dollar Amounts in Millions)[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

The causes of overpayments include manual administrative errors (88.84 percent of overpayments, or $137.15 million) and automated process errors (11.16 percent of overpayments, or $17.23 million) associated with determining consumer eligibility for APTC payments.

Automated process errors generally relate to the FFE's processing of application information and eligibility verification information provided by trusted data sources. The nature of automated process errors may vary between reporting periods. For RY 2024, the primary driver of automated errors was technically improper payments, where the payment was to the right recipient for the right amount, but the payment process did not comply with

applicable statutory or regulatory requirements. The secondary driver of automated errors was related to the FFE failing to demonstrate that certain required consumer attestations were obtained and processed correctly causing an overpayment. Automated process errors (including unexecuted Eligibility Verifications) account for 75.64 percent ($425.79 million) of all improper payments.

Manual administrative errors generally relate to the FFE's processing of additional documentation provided by consumers when the Exchange was unable to verify consumer eligibility using automated processes. Manual eligibility verification involves complex rules and a large variety of documentation types and formats and therefore has a heightened risk of error as compared to automated eligibility verification. The nature of manual administrative errors may vary between reporting periods. For RY 2024, the primary driver of manual errors related to the FFE accepting consumer-submitted documents that did not contain elements required by policy. Manual administrative errors account for 24.36 percent ($137.15 million) of all improper payments.

Combined Improper Payment Information

The APTC is the first of two potential[36] payment streams for the overall Premium Tax Credit program. The second payment stream is the additional Premium Tax Credit claimed on individual tax returns, referred to as the Net Premium Tax Credit (Net PTC). That is, total Premium Tax Credit outlays are equal to APTC payments plus Net PTC claims. The Internal Revenue Service (IRS) measures improper payments associated with Net PTC claims and for CY 2022 reported[37] Net PTC claims of $1.27 billion, improper payments of $362.73 million, and an improper payment rate of 28.54 percent. The combined APTC and Net PTC improper payment estimate is $925.66 million out of $56.98 billion total Premium Tax Credit outlays or 1.62 percent. Similar to the APTC information reported above, this combined APTC and Net PTC information does not reflect payments made by State-based Exchanges.

On their tax return, a consumer may claim a total Premium Tax Credit that is less than the APTC payments made on behalf of the consumer for the tax year. For example, their income for the tax year may exceed what they anticipated when they enrolled in health insurance coverage, resulting in eligibility for a lesser Premium Tax Credit than expected. The amount paid in APTC that exceeds the total Premium Tax Credit they are entitled to is referred to as Excess APTC. A consumer may have an obligation to repay Excess APTC amounts, and such repayments may relate to amounts that are recognized as improper payments. The combined APTC and Net PTC improper payment information does not reflect any effects related to the repayment of Excess APTC.

Statistical Sampling Process

Federally-facilitated Exchange (FFE): HHS reviews a statistically valid random sample of health insurance applications to determine if the FFE properly paid APTC benefits under the statutory and regulatory requirements relating to eligibility and payment determinations.[38] **Figure 16** below depicts the sampling process.

Figure 16: APTC Sampling Process

For RY 2024, HHS reviewed a statistically valid random sample of 2,000 applications representative of all applications with APTC payments processed by the FFE for CY 2022. A contractor obtained the data from each of these applications; formed an independent expectation of the application's outcome, including eligibility and payment

[36] Taxpayers may elect not to receive APTC payments and instead may claim the entirety of the Premium Tax Credit at the time of tax filing.
[37] See the U.S. Department of the Treasury FY 2023 Agency Financial Report for more information.
[38] Relevant regulatory requirements are generally contained within 45 CFR 155.

amount; and compared this expectation to the actual outcome to determine the extent to which discrepancies constituted improper payments.

State-based Exchanges: For CY 2022, 17 states and the District of Columbia did not use the Federally-facilitated Exchange to administer the APTC program and instead operated independent State-based Exchanges.[39] For CY 2022, State-based Exchanges made payments totaling approximately $17.78 billion, or 24.19 percent of total APTC payments made. The improper payment rate and amounts estimated herein do not reflect APTC payments made by State-based Exchanges. HHS began the Improper Payment Pre-Testing and Assessment (IPPTA) program in 2024 to prepare states for the upcoming measurement. HHS will continue to update the AFR in future years with the status of measurement program implementation. As with similar HHS programs, developing an effective and efficient improper payment measurement program requires multiple time-intensive steps, including contractor procurement; developing measurement policies, procedures, and tools; and extensive pilot testing to ensure an accurate improper payment estimate.

APTC Mitigation Strategies and Corrective Actions

HHS mitigates improper payments in APTC through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Systems Automation:** HHS continuously improves automated processes, such as fixing system defects and upgrading the Verify Lawful Presence service with the Department of Homeland Security to enhance accuracy and timeliness. Future automation efforts aim to reduce documentation errors and improve adjudication.
Training	• **Eligibility Support Contractor Education:** HHS provides thorough onboarding, annual refresher courses, and ad-hoc training for eligibility personnel. In FY 2024, additional training focused on Data Matching Issues, casework, and outreach.
Audits	• **Internal and External Controls:** The Exchanges undergo annual testing of internal controls covering both automated and manual processes. External audits by OIG and GAO review APTC eligibility determinations to ensure compliance with federal laws and regulations.
Predictive Analytics	• **Agent/Broker Risk Monitoring:** HHS uses a risk-based approach to monitor agents and brokers in the Exchanges, analyzing enrollments and complaints to detect fraud early. Swift action, including suspending or terminating an agent or broker's ability to sell Exchange plans, is taken when suspicious activity is identified.

7.7 PROVIDER RELIEF FUND (PRF)

PRF Calculations and Findings

PRF paid an estimated 99.94 percent of total outlays properly, amounting to $6.17 billion. The estimated improper payments are 0.06 percent, or $3.82 million.

[39] For 2022, states not using the Federally-facilitated Exchange include California, Colorado, Connecticut, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Washington. Additionally, Washington D.C. did not use the Federally-facilitated Exchange.

The reviewed PRF payments were calculated using applications for funding and supporting financial documentation. The identified errors include:

- **Lack of Supporting Documentation:** Some payments were made using applicant information without any supporting documentation, such as tax filings or financial statements. The estimated amount is $3.78 million, accounting for 99.13 percent of all improper payments.
- **Errors in Applicant Data:** Improper payments occurred because applicant-entered data was incorrect and did not match supporting documentation. The estimated amount is $0.03 million, accounting for 0.87 percent of all improper payments.

Statistical Sampling Process

HHS used a stratified random sampling method to select a statistically valid sample from PRF payments disbursed between March 27, 2022, and March 26, 2023. Payments were issued in batches, or "waves," and the population was stratified based on the payment wave's risk score and individual payment amounts. HHS assigned a risk score to each wave, assessing the likelihood of payment errors, and identified only low- and medium-risk waves—no high-risk waves were found. Payments within each wave were further stratified by amount, with a census stratum defined for large payments. HHS then selected a random sample from each stratum to test and extrapolated the results for improper and unknown payments.

PRF Mitigation Strategies and Corrective Actions

Following the passage of the *Fiscal Responsibility Act* (FRA) in June 2023 and the related rescission of program funds, no further PRF payments will be issued. For the final year of PRF payments, the first two strategies include Automation and Behavioral/Psychological Influence which have been completed and the remaining mitigation strategies and actions are still on-going as part of the post-payment process.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Automation	• **Robotic Process Automation:** HHS implemented robotic process automation to streamline manual validation, reducing errors and improving efficiency in post-payment reviews of PRF applications. This ensures more accurate detection of improper payments through enhanced internal controls.
Behavioral/Psychological Influence	• **Application Portal:** HHS improved data precision by changing how providers report patient care revenue, shifting from percentages to dollar amounts for greater accuracy.
Training	• **Payment Disbursement Training:** HHS provides training to personnel and contractors on conducting payment audits and reviews, focusing on compliance with federal laws and internal policies to ensure proper disbursement. The trainings help personnel detect input errors and identify missing documentation in provider reports during the post-payment process.
Internal Process or Policy Change	• **Process Improvement:** HHS standardized payment calculations and eligibility verification, tracking guidelines to avoid discrepancies and improve program consistency. • **Risk Management**: HHS developed a risk management process to identify and mitigate risks within the PRF program, helping to prevent improper payments. • **Pre-Payment Controls:** HHS. introduced manual validation and peer review processes for high-dollar payments to catch errors before disbursements are made.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Cross Enterprise Sharing	• **Post-Payment Controls and Review:** HHS employs a comprehensive post-payment analysis process to detect and investigate potential payment errors, including improper payments. This includes in-depth reviews and enhanced records management to support future payment methodology changes and improve the post-payment review process.
Audits	• **Provider Reporting and Audits:** HHS established post-payment reviews, audit strategies, statutory reporting, and system enhancements to detect errors and documentation deficiencies, ensuring payment integrity through the recovery of improper payments. Providers are required to comply with audit agreements and cooperate with HHS, HHS OIG, or the Pandemic Response Accountability Committee during post-payment audits and reviews. • **Internal and External Reviews:** HHS undergoes internal control reviews in compliance with OMB Circular A–123, along with external audits by GAO and OIG to identify risks and issues.
Predictive Analytics	• **Anomaly Detection:** HHS uses a system to flag anomalies, such as input errors and missing documentation, for further investigation, helping to identify and correct errors or confirm valid payments.

7.8 UNINSURED PROGRAM (UIP)

UIP Calculations and Findings

UIP paid an estimated 99.09 percent of total outlays properly, amounting to $19.09 billion for the 24-month period sampled. The estimated improper payments are 0.91 percent, or $175.81 million.[40]

The UIP claims reimbursement error types are as follows:

- **Incorrect Calculation of Payment:** An incorrect rate used to calculate payments resulted in an estimated $173.52 million in improper payments, accounting for 98.70 percent of all improper payments.
- **Insufficient Documentation:** One testing procedure for improper payments involves matching parent and subsidiary Taxpayer Identification Numbers (TINs) to ensure accurate payments. When the provider's TIN in the sample data did not match the TIN in the supporting documentation, it resulted in an improper payment of $2.29 million, accounting for 1.30 percent of all improper payments.

Statistical Sampling Process

HHS completed measurements for two sampling periods in RY24 using a stratified random sampling method to select a statistically valid sample from the claims population for UIP reimbursements. Samples were taken from March 27, 2021, to March 26, 2022, and from March 27, 2022, to March 26, 2023. The population was stratified by payment amount and grouped into exclusive categories—positive, negative, or zero-dollar amounts—to prevent duplication. Random samples of 573 UIP payments for the first period and 473 UIP payments for the second period were tested, with results extrapolated to estimate improper payments. The rates were combined to produce a single estimate for reporting purposes this year. Due to limitations in data available, HHS's sampling and estimation methodology plan does not perform insurance verification checks to determine if patients had existing health insurance coverage. Program policies established in the earliest days of the UIP in 2020 were intended to maximize access to services

[40] The UIP improper payment estimate is 0.91 percent for FY 2023 and 0.77 percent for FY 2024.

during times of critical need using reasonable data collection processes while employing a number of pre-payment risk mitigation safeguards. HHS is aware that, retrospectively, other auditors have used different methodologies and additional data sets that were not available to UIP claims processors during the COVID-19 pandemic when maintaining access to timely testing, treatment, and vaccinations was paramount. By not measuring the patient eligibility component, the improper payment rate reported may be understated.

The UIP stopped accepting claims in April 2022 and completed making payments. With very limited administrative dollars remaining in a program that is no longer operational, pursuing potential recoveries offers a more productive use of resources than designing new approaches to an existing and valid methodology.

UIP Mitigation Strategies and Corrective Actions

Following the passage of the *Fiscal Responsibility Act* (FRA) in June 2023 and the related rescission of program funds, no further UIP claims will be reimbursed. Despite the shift in focus away from UIP claims reimbursements, HHS mitigates improper payments in UIP through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Internal Process or Policy Change	• **TIN Matching for Accurate Payment Verification:** HHS expanded its payment policy to include matching parent and subsidiary TINs to ensure payments were made to the correct provider and for the correct amount.
Training	• **TIN Matching:** HHS provided training to personnel and contractors on TIN matching and documentation retention to efficiently assess UIP claims.
Audits	• **Recipient Assessment:** HHS conducts reviews of UIP claims reimbursement recipients to ensure compliance with legislation and UIP Terms and Conditions.

7.9 Temporary Assistance for Needy Families (TANF)

TANF Calculations and Findings

Statutory limitations, specifically Section 417 of the Act (42 U.S.C. 617), preclude HHS from requiring states to participate in or report the data necessary for an improper payment measurement. As a result, the TANF program is not reporting an estimate.

TANF Mitigation Strategies and Corrective Actions

Because HHS lacks the authority to mandate state participation in a TANF improper payment measurement, it cannot gather essential data for implementing and reporting mitigation strategies and corrective actions. While states administer TANF and are responsible for reducing improper payments, HHS still supports state-level efforts to enhance TANF program integrity and prevent improper payments through the following actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Internal Process or Policy Change	• **Risk Assessment:** HHS completed improper payment and fraud risk assessments for TANF in FY 2022 and FY 2024. These assessments help identify areas for risk mitigation and inform improvements in supporting states. • **Budget Proposal:** In the FY 2025 President's Budget, HHS proposed new authority to collect detailed data on TANF spending by non-governmental subrecipients. This would enhance oversight and help establish an improper payment rate.

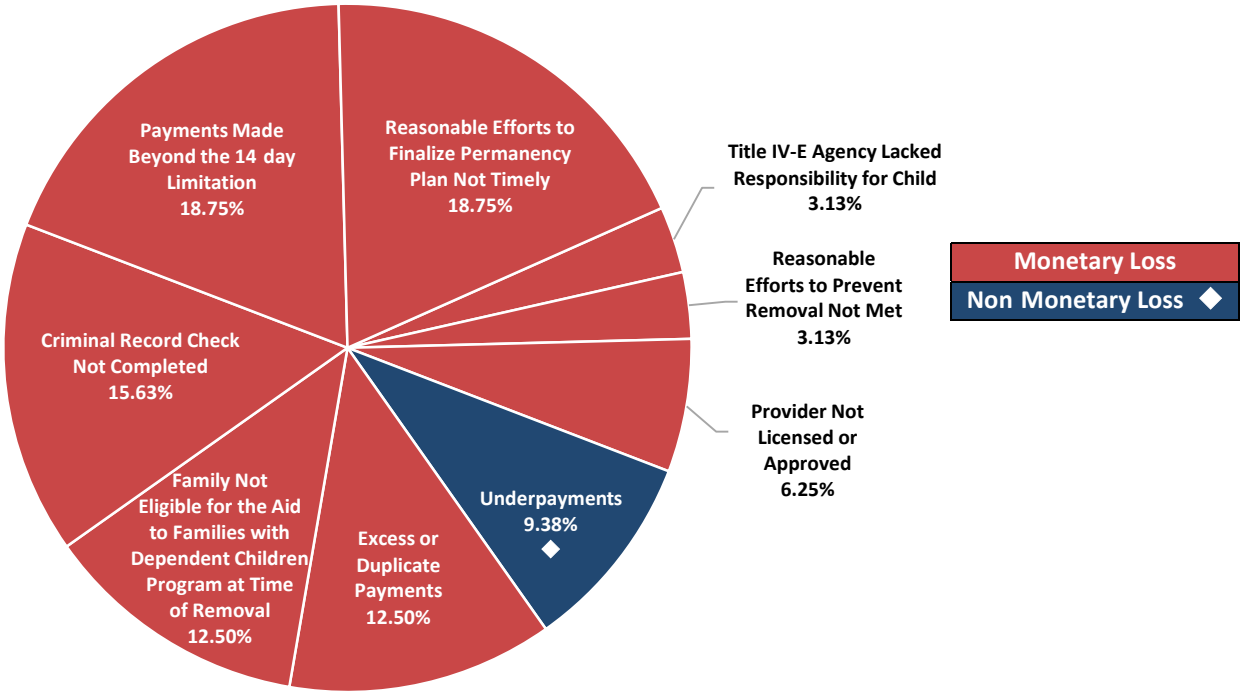
Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Cross Enterprise Sharing	• **Data Sources:** States use systems like the Public Assistance Reporting Information System, National Directory of New Hires, and Income and Eligibility Verification System to reduce improper payments in TANF.

7.10 FOSTER CARE

Foster Care Calculations and Findings

Foster Care paid an estimated 95.18 percent of total outlays properly, amounting to $1.23 billion. The estimated improper payments are 4.82 percent, or $62.32 million. The improper payments result exclusively from state agencies incorrectly classifying cases and processing payments. **Figure 17** below presents the most common administrative or process payment errors in FY 2024.

Figure 17: Frequency of Payment Errors, by Monetary and Non-Monetary Loss Categories, for FY 2024 Title IV-E Foster Care Improper Payments[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Statistical Sampling Process

In FY 2024, HHS resumed conducting onsite Title IV-E reviews, following a nearly four-year suspension due to COVID-19. About one-third of the states will be reviewed each FY. During the period of the suspension, HHS completed an updated Title IV-E Foster Care Eligibility Review Instrument (IV-E Instrument) and Instructions to reflect changes in eligibility for foster care maintenance payments made by the *Family First Prevention Services Act*,[41] primarily relating

[41] The *Family First Prevention Services Act*, enacted as *Title VII of the Bipartisan Budget Act of 2018*, changed the federal statutory requirements for staff safety checks at child care institutions and placed limitations on claiming for non-family-based foster care settings. All states became subject to all new limitations no later than October 1, 2021.

to placements of children in child care institutions or congregate care. While the review instrument has been updated to reflect current eligibility criteria, the methodology for conducting reviews and measuring improper payments is unchanged from prior year reporting. The FY 2024 estimate of improper payments for Foster Care is based on data from the first six states reviewed in FY 2024. As the balance of states are reviewed, they will be included in future annual estimates of improper payments. All states will be reviewed by FY 2027.

Foster Care Mitigation Strategies and Corrective Actions

As Foster Care is administered by states, efforts to mitigate improper payments occur at the state level. HHS mitigates improper payments in Foster Care through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **Training for HHS Staff and Title IV-E Agencies**: HHS conducted trainings for federal and state reviewers on the Title IV-E Review Instrument and Instructions to prepare for Title IV-E Reviews. • **Office Hours for Federal Staff:** Monthly "office hours" are held to address specific eligibility questions and review instrument sections for federal staff and Regional Office teams. • **Training Videos**: HHS is developing on-demand training videos for the Title IV-E Review Instrument, to be released in FY 2025 for both federal staff and Title IV-E agencies. • **Program Improvement Support:** HHS provides ongoing guidance and communication with states to strengthen Title IV-E programs and improve their effectiveness.
Internal Process or Policy Change	• **Updated Title IV-E Review Website:** HHS regularly updates the Title IV-E Review section of its website with review guides, schedules for FY 2024-2026, and final reports. • **Outreach on Federal Requirements:** HHS reviewed state policies and clarified eligibility requirements to help states understand complex Title IV-E foster care payment regulations.
Cross Enterprise Sharing	• **Quality Improvement Collaboration:** HHS worked with state Title IV-E agencies to improve program compliance and share successful strategies. In addition, at the conclusion of each IV-E Review, HHS issues a detailed state-specific report on identified improper payments and promising practices; imposes disallowances for identified overpayments; and requires a Program Improvement Plan for states not in substantial compliance. • **Comprehensive Child Welfare Information System (CCWIS):** States may receive federal financial support to develop and implement a Comprehensive Child Welfare Information System (CCWIS) in accordance with federal regulations. • **CCWIS Self-Assessment Tools:** HHS provides Title IV-E agencies with a technical bulletin containing information on technical assistance, self-assessment tools (including one for Title IV-E Foster Care Eligibility), and CCWIS monitoring reviews.
Audits	• **Claims Reviews:** HHS continuously reviews Title IV-E quarterly claims to address and correct any errors or anomalies in state submissions.

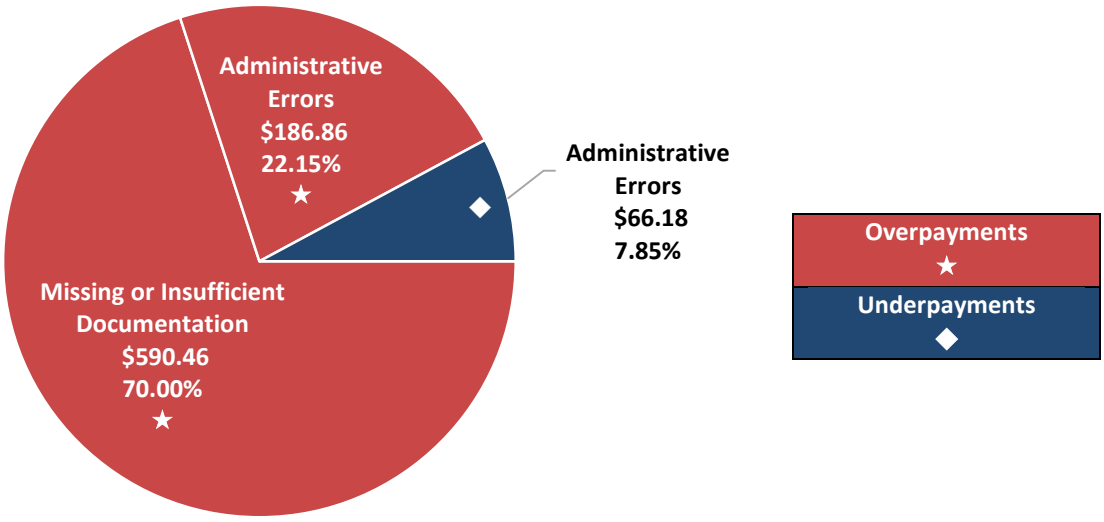
7.11 CHILD CARE AND DEVELOPMENT FUND (CCDF)

CCDF Calculations and Findings

CCDF paid an estimated 95.07 percent of total outlays properly, amounting to $16.25 billion. The estimated improper payments for RY 2024 are 4.93 percent, or $843.50 million. The RY 2023 estimate was 3.55 percent, and HHS attributes the increase to the challenges caused by COVID-19. States faced delays in implementing planned changes to policies, procedures, and information technology systems to fully comply with the 2014 reauthorization of the CCDBG Act as resources were diverted to COVID-19 efforts. HHS anticipated the error rate may fluctuate as states implemented and then phased out time-limited policies and flexibilities associated with supplemental COVID-19 funding.

Figure 18 shows that overpayments were considerably larger (at about 92.00 percent of all improper payments or $776.05 million) than underpayments (at about 8.00 percent of all improper payments or $67.45 million). There were no unknown payments.

Figure 18: RY 2024 CCDF Estimated Payment Error Types [1] (Dollar Amounts in Millions)

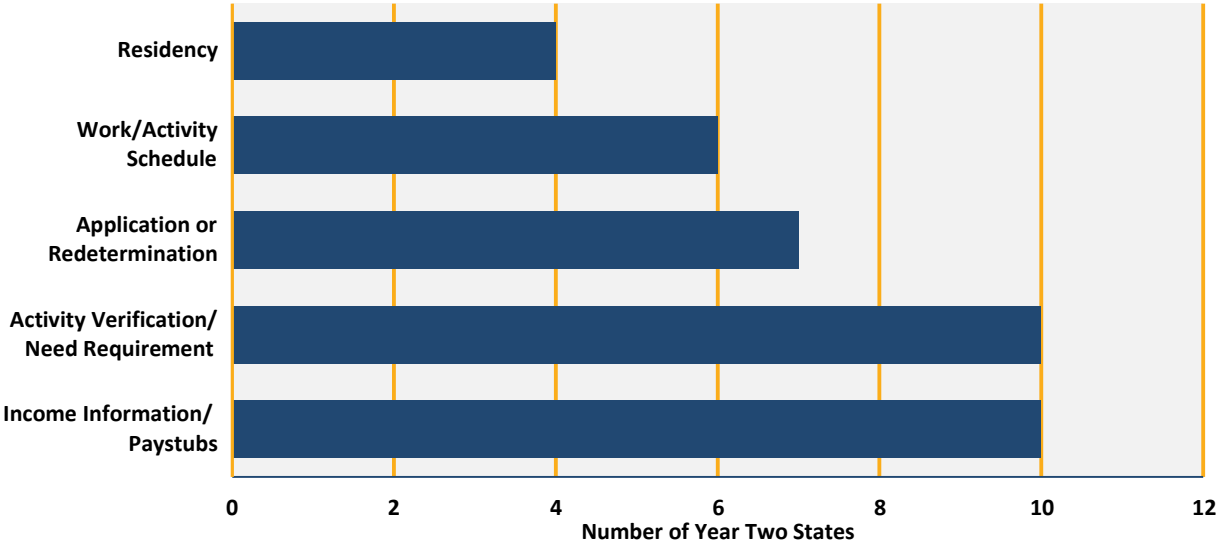


[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

The Agency Financial Report data reflects only what CCDF refers to as payment errors, which are errors that create a monetary discrepancy between the subsidy amount as determined by the reviewer and the sample month payment amount. CCDF further classifies its payment errors as (1) missing or insufficient documentation errors in which required documentation was not evident in the case record, and (2) administrative errors, such as those caused by failure to correctly apply policy.

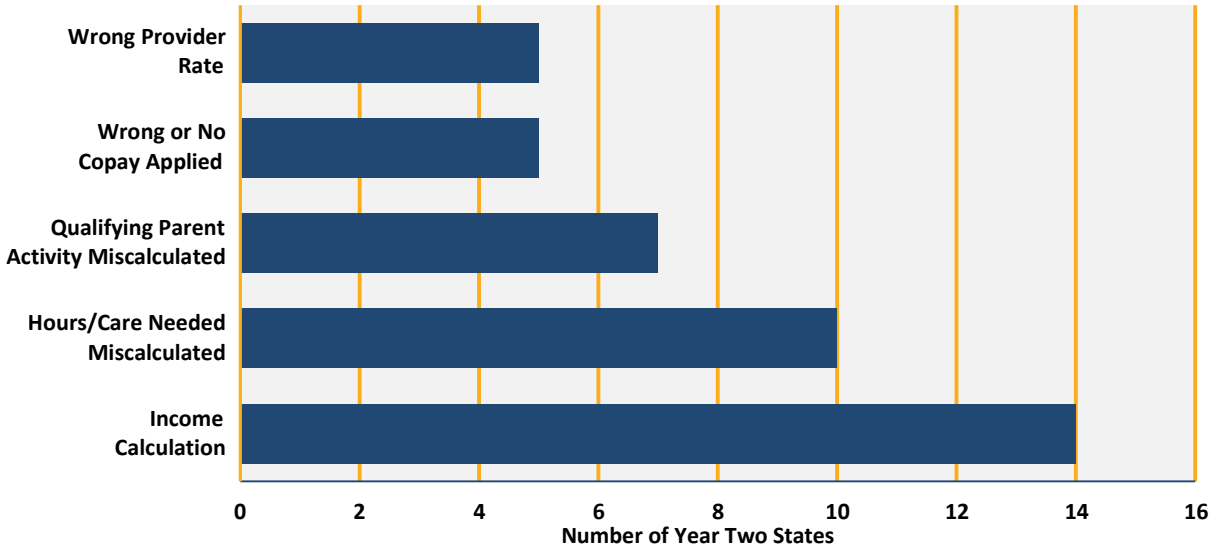
Missing or insufficient documentation errors totaled $590.46 million and accounted for approximately 60.60 percent, or 506 of the 835 total number of errors identified in the Year Two reviews. **Figure 19** highlights the most frequently cited MID errors in the Year Two reviews.

Figure 19: Most Frequently Cited Categories of Errors Due to Missing or Insufficient Documentation for CCDF



Administrative errors totaled $253.04 million and represent 329 of the 835 total number of errors noted in the Year Two reviews, or approximately 39.40 percent. **Figure 20** highlights the types of administrative errors most frequently identified in the Year Two reviews.

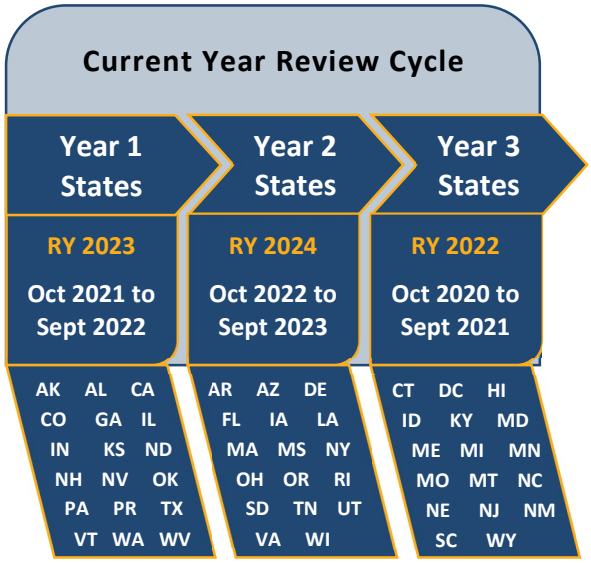
Figure 20: Most Frequently Cited Categories of Administrative Errors for CCDF



Statistical Sampling Process

The CCDF improper payments methodology uses case-record reviews to determine if child care subsidies were paid properly for services provided to eligible families. The states, the District of Columbia, and Puerto Rico (hereafter all referred to as "states") are split into three cohorts, such that each cohort is reviewed once every 3 years as shown in **Figure 21**.

Figure 21: CCDF Improper Payment Rate Review Cycle and RY



In addition to federal rules, states have varying requirements for establishing and verifying eligibility. The methodology enables states to determine error types and their sources to reflect policies and procedures unique to each state. For CCDF's improper payments methodology, see Improper Payments Error Rate Review Process.

The current methodology incorporates the following: (1) drawing a statistical sample from a universe of paid cases; (2) measuring improper payments; and (3) requiring states with improper payment estimates exceeding 10 percent to submit a corrective action plan.

CCDF Mitigation Strategies and Corrective Actions

As CCDF is administered by states, efforts to reduce improper payments are carried out at the state level. States are required to report the causes of errors identified in both the previous and current review cycles, along with the actions planned to address these causes. HHS assists states in developing mitigation strategies and corrective actions.

Year Two states plan to:

- Provide guidance and training to eligibility workers;
- Implement IT system fixes and updates;
- Review and update policies, procedures, and manuals;
- Provide individual feedback, technical assistance, and corrective actions to eligibility staff and workers;
- Develop new tools and procedures for eligibility staff;
- Perform continuous reviews; and
- Conduct site visits, audits, and monitoring of local agencies.

HHS mitigates improper payments in CCDF through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Training	• **State Assistance and Root Cause Analysis:** HHS provides on-site assistance and technical support to help states address root causes of errors and meet CCDF requirements through policy and procedure changes. • **National Center on Subsidy Innovation and Accountability:** HHS funds the National Center to offer technical assistance to states and territories on program integrity, accountability, and compliance with reauthorization requirements. • **IT System Development Support**: HHS provides technical assistance to states developing or improving IT systems to enhance practices and reduce errors. • **Improper Payments Training:** HHS offers training on improper payment methodologies, including error rate reviews, and shares best practices among states. • **Joint Case Reviews:** HHS conducts joint case reviews with states and federal staff to improve consistency in error measurement and provide technical assistance on review methodologies.

7.12 HEAD START

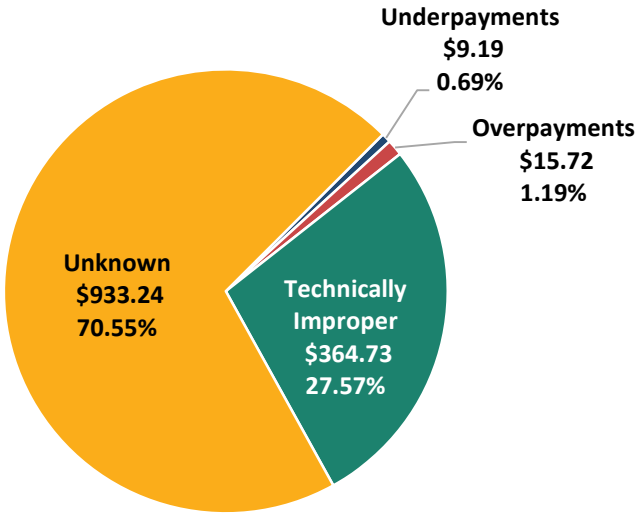
Head Start Calculations and Findings

Head Start paid an estimated 88.02 percent of total outlays properly, amounting to $9.72 billion. The estimated improper payments are 11.98 percent, or $1.32 billion.

The majority of overpayments resulted from missing or insufficient documentation errors (79.34 percent of all overpayments or $12.47 million). The largest portion of overpayments were related to Supplies (36.39 percent of overpayments or $5.72 million), followed by Salaries and Wages and Fringe Benefits (29.29 percent of overpayments or $4.60 million). A total of 46 grant recipients accounted for the unknown payment amount. Two of these recipients were unable to provide correct transaction documentation that could be tested under the methodology. One recipient, with an atypical structure when compared to the majority of Head Start recipients, and experiencing turnover in essential leadership and fiscal roles, accounts for 12.72 percent of all improper payments or $168.23 million. This recipient is receiving increased training and technical assistance and oversight activities. The second recipient, denoting time and an overall miscomprehension of the improper payments study accounts for 7.41 percent of all improper payments or $98.07 million.

Figure 22 below provides a breakdown of the Head Start estimate by payment type.

Figure 22: RY 2024 Head Start Estimated Payment Types[1] (Dollar Amounts in Millions)



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Statistical Sampling Process

The Office of Head Start (OHS) annually awards over $10 billion in federal grants to approximately 1,800 recipients. For RY 2024, the period under review is October 1, 2022, through September 30, 2023. HHS selected a statistically valid sample consisting of 198 grant recipients at the first stage and 10 transactions per recipient at the second stage, for a total of 1,980 transactions selected for review. Two of the sampled recipients submitted their transactions in an incorrect format that could not be reviewed, so these two recipients were counted, for purposes of the improper payment estimate, as having 100 percent unknown improper payments. Excluding these two recipients, 1,960 transactions were reviewed.

Head Start Mitigation Strategies and Corrective Actions

HHS mitigates improper payments in Head Start through the following strategies and actions:

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
Audits	• **Recovery Actions:** HHS will take recovery actions on payment errors identified through improper payment reviews and audits by the HHS Office of Inspector General, program reviews, and Single Audits.
Internal Process or Policy Change	• **Consultants:** In FY 2025, HHS will secure expert consultant services to assess approaches to support grantee processes and internal oversight procedures. • **Enhanced Monitoring:** HHS enhanced its oversight to include transaction reviews and will issue Information Memorandums and Program Instructions as needed to maintain fiscal and program integrity. • **Policy:** HHS will issue sub-regulatory guidance to clarify fiscal and program requirements.
Training	• **Fiscal Training:** In FY 2024, HHS provided training through Regional Training and Technical Assistance Networks and National Centers in areas such as procurement, source documentation, cost allocation, and other fiscal challenges to improve financial management practices.

Key Actions to Address Payment Integrity Risks	
Mitigation Strategy or Corrective Action	**Description and Impact**
	• **Improper Payment Training**: HHS will ensure recipients and sub-recipients understand the purpose and processes around improper payments and expectations related to the study. • **Financial Recordkeeping Training:** HHS will communicate comprehensive and practical approaches to managing financial transactions effectively, and keeping track of financial records, with the goal of accurate financial management.

8.0 RECOVERY AUDIT REPORTING

HHS has a risk-based strategy to implement PIIA's recovery auditing provisions. Specifically, HHS focuses on implementing recovery audit programs in Medicare and providing a framework for states to implement recovery audit programs in Medicaid, which together account for most of HHS's outlays. HHS is progressing in recovering overpayments in Medicare and Medicaid and, most importantly, implementing corrective actions to prevent improper payments, as described in Section 7.0*: Program-Specific Reporting Information* and the following subsections. HHS considers lessons learned from these experiences as it implements this requirement. Reported recoveries in this section represent the amounts recovered in FY 2024, which may encompass various reporting years in which HHS identified overpayments.

Medicare FFS Recovery Audit Contractors (RACs)

Section 1893(h) of the Act requires the establishment of a nationwide Medicare FFS Recovery Audit Program conducted by RACs. The mission of the Medicare FFS Recovery Audit Program is to identify and correct overpayments made on claims for healthcare items and services provided to beneficiaries, to identify and correct underpayments to providers, and to provide information that allows HHS to implement corrective actions that will prevent future improper payments. The RACs review post-payment Medicare FFS claims in defined geographic regions.[42] As required by Section 1893(h), RACs are paid on a contingency fee basis.

The Medicare FFS RAC program identified approximately $486.64 million in overpayments and recovered $382.21 million. Outpatient hospital and professional service claims represented the majority of Medicare FFS RAC collections. Medicare FFS RACs made recommendations to HHS to improve program operations and prevent future improper payments. These recommendations resulted in proposed RAC topics for review. More information on proposed review topics and topics approved for review can be found at the Medicare FFS RAC program website.

Medicare Secondary Payer (MSP) RACs

The MSP RAC, also known as the MSP Commercial Repayment Center (CRC), is one contractor with national jurisdiction. The CRC reviews HHS collected information regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP) and situations where a Non-GHP (e.g., Workers' Compensation entity or No-Fault insurer) has or had primary payment responsibility. When GHP information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers these payments from the entity that had primary payment responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). At the end of FY 2016, the CRC also began recovering certain conditional payments made by Medicare FFS when HHS identifies a Non-Group Health Plan with primary payment responsibility.

[42] One Medicare FFS RAC reviews national DME, home health, and hospice claims, and four Medicare FFS RACs review other types of claims in four geographic regions.

The CRC identified approximately $426.29 million and collected $284.66 million in mistaken payments, and recommended HHS improve program operations by:

- Supporting the development of machine learning to improve the claim filtering process, which is set to be implemented in early 2025.This will enhance accuracy and efficiency in identifying related claims, thereby reducing a significant number of disputes, appeals and associated costs; and
- Automating the case assignment process in the case management system to optimize work inventory management and enhance operational efficiency.

Medicare Part C and Part D RACs

Section 1893(h) of the Act expanded the RAC program to Medicare Part C and Part D. HHS has taken many actions over the years to implement the requirement. These steps are discussed on page 243 of HHS's FY 2021 AFR.

Despite their success in Medicare FFS, RACs have found Medicare Part C does not represent an appealing business case for them because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes. Therefore, HHS's primary corrective action on Part C payment error is the contract-specific RADV audits. The RADV program is operated with the support of contractors. Given the purpose of RADV audits, HHS believes that the RADV audit program performs Part C RAC functions.

Similar to the Part C RAC, HHS believes that the PPI-MEDIC performs the Part D RAC functions. The PPI-MEDIC's workload is substantially like that of a Part D RAC and has a robust program to identify improper payments. The PPI-MEDIC performed audits that identified potential improper payments and conducted education and outreach for Part D plan sponsors. As stated in Section 7.4: *Medicare Prescription Drug Benefit (Part D)*, based on the PPI-MEDIC's national audits and Part D plan sponsor self-audits, HHS recovered $56.44 million from Part D sponsors during FY 2024 quarters 1-3.[43]

State Medicaid RACs

Section 1902(a)(42)(B) of the Act required states to implement Medicaid RAC programs. However, federal law allows states to request exemptions from the Medicaid RAC requirements, and many states operated under an approved exemption (for example, because of the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS). During FY 2024, State Medicaid RAC federal-share recoveries totaled $157.05 million and reflect overpayments collected, adjusted, or refunded to HHS, as reported by states on the Form CMS-64, Medicaid Statement of Expenditures.[44]

Recovery Auditing Reporting Table

Table 3 provides information on HHS's recovery auditing programs and other efforts to recover improper payments.

[43] HHS will report the full fiscal year recoveries from the PPI-MEDIC's national audits and Part D plan sponsor self-audits in the forthcoming Annual Report to Congress on the Medicare and Medicaid Integrity Programs.
[44] This amount may differ from the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.

Table 3: Overpayments Recovered

FY 2024 (in Millions)

Program or Activity	Overpayments Recovered through Recovery Audits			Overpayments Recovered Outside of Recovery Audits	
	Amount Identified	Amount Recovered [1]	Recovery Rate	Amount Identified	Amount Recovered [1]
CMS Error Rate Measurements [2]				$39.73	$32.15
Medicare FFS Recovery Auditors	$486.64	$382.21M	78.54%		
MSP Recovery Auditor	$426.29	$284.66	66.78%		
Medicare Contractors [3]				$14,696.87	$11,752.38
Medicaid Integrity Contractors—Federal Share [4]				$52.88	$16.69
State Medicaid Recovery Auditors—Federal Share [5]	N/A	$157.05	N/A		
ACF Error Rate Measurements [6]				$0.71	$0.61
ACF OIG Reviews [7]				$1.10	$0.96
Single Audits [8]				$167.65	$153.36
HRSA National Health Service Corps				$30.25	$7.49
TOTAL [9]	**$912.93**	**$823.92**	**90.25%**	**$14,989.19**	**$11,963.64**

Notes:

1. Unless otherwise noted, the amount reported in the Amount Recovered column is the amount recovered in FY 2024, regardless of the year HHS identified the overpayment.
2. This row includes recoveries from Medicare FFS (via the Comprehensive Error Rate Testing program), as well as Medicaid and CHIP (via the Payment Error Rate Measurement program). The overpayments identified in the Comprehensive Error Rate Testing sample for RY 2024 were $38,298,739.62. The MACs recover these overpayments via standard payment recovery methods. As of the report publication date, MACs reported collecting $30,509,473.33 or 79.66 percent of these overpayments. For Medicaid and CHIP, HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. The Act and related regulations govern the recoveries of Medicaid and CHIP improper payments. States reimburse HHS for the federal share of overpayments. Section 1903(d) of the Act allows states up to 1 year from the date of discovery of an overpayment for Medicaid and CHIP services to recover, or to attempt to recover, such overpayments from the provider or supplier before making an adjustment to refund the federal share of the overpayment. The overpayments observed in the PERM sample for RY 2024 were $1,212,815.90 for Medicaid and $214,685.56 for CHIP. HHS recovered $1,551,133.00 for Medicaid and $85,364.00 for CHIP. The amounts recovered were for overpayments identified in prior report periods and, therefore, do not represent a proportion recovered from the identified overpayment amount for this report period. This row does not include overpayments identified or recovered via the measurement of the Medicare Part C, Medicare Part D, or Federally-facilitated Exchange APTC.
3. This row shows the amounts reported by Medicare FFS Contractors, excluding the amounts shown on other rows for the Medicare FFS Recovery Auditors and the Medicare FFS Error Rate Measurement contractor.
4. Medicaid Integrity Contractors (UPICs) identified total overpayments that include both federal and state shares. However, HHS reports here only the federal share across audits. The amount recovered may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.
5. Only the amount recovered is available. The amount recovered may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.
6. Amount Identified information comes from the reviews underlying the RY 2024 estimates for the CCDF, Foster Care, and Head Start programs Amounts Recovered may include recoveries based on FY 2024 estimates and prior years' identified amounts. For CCDF, states must recover child care payments resulting from fraud and have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of unintentional worker error identified in the improper payments review. CCDF contributed $105,661 to the Amount Identified and $13,043 to the Amount Recovered, representing improper payments recovered in FYs 2021 through 2023 by the Year Two states based on reviews for RY 2021 plus the amounts identified for New York in FY 2018. New York received a waiver from reporting in FY 2021 due to challenges related to COVID-19. As a result of conducting Foster Care eligibility reviews in six states, HHS identified and recovered $598,291 in Title IV-E improper payments (comprised of $335,341 in disallowed maintenance payments and $262,950 in disallowed administrative payments). For Head Start, HHS identified $6,354 in improper payments during reviews for RY 2024 and made no recoveries; however, Head Start will continue recovery activities in FY 2025.
7. This row contains Amount Identified information from all HHS OIG reports of ACF funding recipients across various ACF programs and reflects the questioned costs amounts identified by the auditors that were sustained by ACF between August 1, 2023 and July 31, 2024.
8. This row includes information for all Divisions and represents results for the full FY 2024.
9. Totals do not necessarily equal the sum of the rounded component.

FY 2024 Top Management and Performance Challenges Identified by the Office of Inspector General

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

DATE: October 29, 2024

TO: Xavier Becerra, Secretary

THROUGH: Elizabeth J. Gramling, Executive Secretary

FROM: Christi A. Grimm, Inspector General

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2024

This memorandum transmits the Office of Inspector General's (OIG's) list of top management and performance challenges facing the Department of Health and Human Services (HHS or the Department). The Reports Consolidation Act of 2000, P.L. No. 106-531, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

HHS's top management and performance challenges for fiscal year 2024 are:

1. Public Health
2. Financial Integrity
3. Medicare and Medicaid
4. Beneficiary Safety
5. Data and Technology Security

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the people who are enrolled in these programs. If you have any questions or comments, please contact me, or your staff may contact Megan Tinker, Chief of Staff, at (202) 539-6271 or Megan.Tinker@oig.hhs.gov.

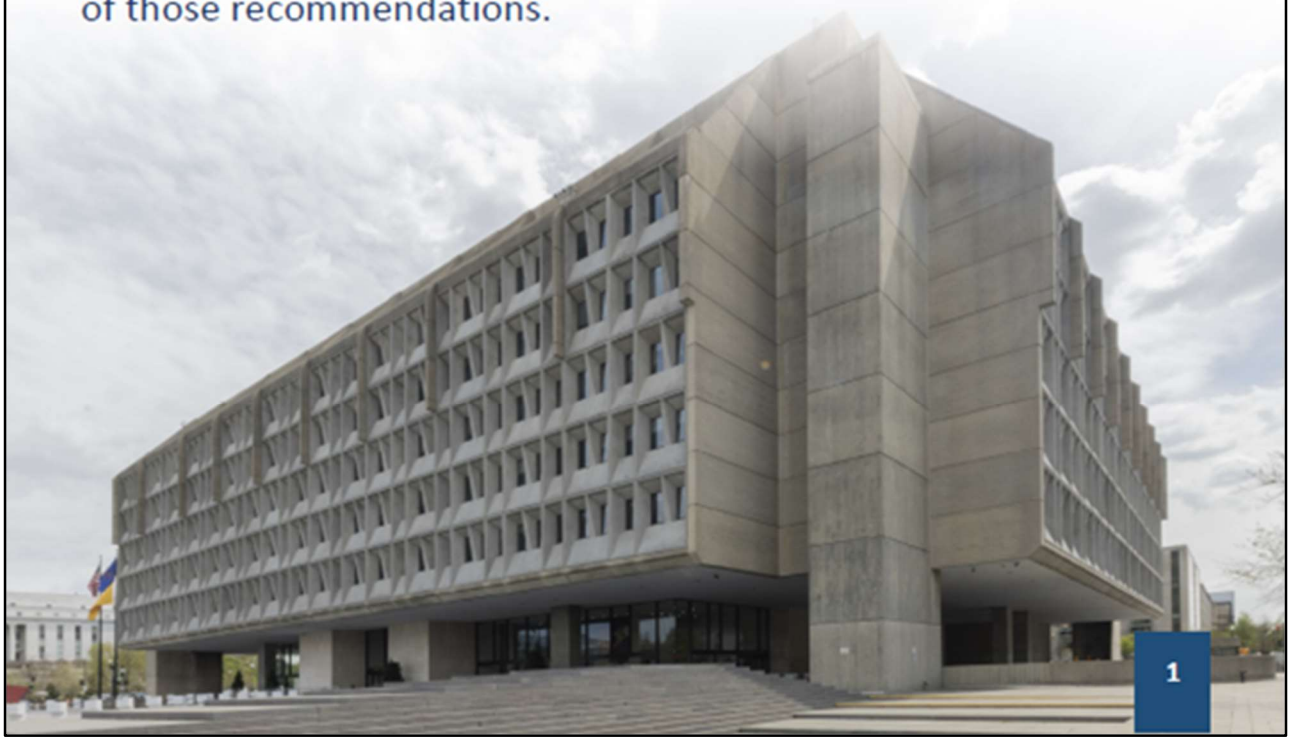

Top Management & Performance Challenges Facing HHS
2024
Department of Health and Human Services
Office of Inspector General

Contents

Introduction

Every year, the Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) fulfills its statutory obligation to produce the *Top Management and Performance Challenges Facing HHS*. This document helps the Department fulfill its mission to enhance the health and well-being of all Americans by directing the Department's focus on the top management and performance challenges outlined herein. While the Department has made efforts to address the challenges, considerable opportunities exist for further progress.

OIG's website offers additional oversight resources, including all reports mentioned here, OIG recommendations to improve Department programs and reduce vulnerabilities, and the status of those recommendations.



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1 | Public Health

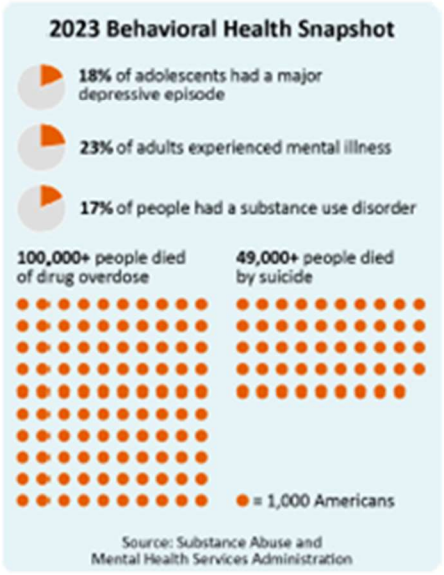
Elements of the Challenge

- Addressing the mental health and substance use disorder crises
- Improving maternal health
- Strengthening emergency preparedness and response capabilities
- Ensuring the safety, effectiveness, and availability of products regulated by the Food and Drug Administration

HHS's mission is to enhance the health of all Americans. HHS must work to better safeguard public health, improving lives and well-being, while reducing negative health effects.

Addressing the Mental Health and Substance Use Disorder Crises

In 2023, 18.1 percent of American adolescents had a major depressive episode, 22.8 percent of American adults experienced mental illness, and 17.1 percent of Americans had a substance use disorder. Provisional data for 2023 estimate that 49,315 Americans died by suicide, and 107,543 Americans died from drug overdoses. Challenges obtaining high-quality care for mental health and substance use compound the devasting effects of the Nation's mental health and substance use disorder crises.



HHS has pursued the strategy outlined in its *HHS Roadmap for Behavioral Health Integration* and invested in initiatives to help tackle the mental health and substance use disorder crises. HHS programs must continue to improve behavioral health care and support, such as by expanding community-based prevention efforts; enhancing access to affordable behavioral health treatments; and developing a diverse behavioral health workforce that can serve the public well and meet the needs of people from diverse backgrounds, understandings, and communication abilities.

Improving Maternal Health

Too many Americans die during pregnancy, childbirth, and the postpartum period. More than 80 percent of these pregnancy-related deaths are preventable. HHS has invested in efforts to prevent pregnancy-related deaths and improve maternal health, launched a National Maternal Mental Health Hotline (1-833-TLC-MAMA), released a *National Strategy to Improve Maternal Mental Health Care*, and announced the Centers for Medicare & Medicaid Services (CMS's) *Transforming Maternal Health* Model. HHS must continue to work to improve pregnancy-related and postpartum care and to eliminate racial, ethnic, geographic, and socioeconomic disparities in health outcomes.

Strengthening Emergency Preparedness and Response Capabilities

Public health emergencies (PHEs), such as communicable diseases, natural disasters (e.g., storms, fires), and human-caused disasters, severely strain public health and medical infrastructure. As PHEs increase in frequency and severity, HHS must build resilience and enhance preparation and response efforts to limit negative impacts on HHS programs and the public when these emergencies occur. Additionally, HHS must strengthen the Nation's emergency preparedness and response capabilities by enhancing public health infrastructure, including establishing highly functional data systems with accurate information about risk and response; a well-developed public health workforce; and mechanisms for effective coordination with States, localities, Tribes, and Federal intragovernmental partners. HHS must foster public trust and improve communication to better lead response and recovery in future PHEs.

HHS is working with stakeholders to equip the health care system for response and recovery; provide surge and behavioral health support; and deliver public health supplies needed for patient care during disasters, especially for individuals with disabilities, older adults, children, underserved communities, and institutional settings. HHS efforts thus far include the release of a plain language checklist to help first responders provide services to individuals with limited English proficiency and individuals with disabilities during emergency response and recovery efforts. Additionally, CMS published acute respiratory illness reporting requirements for hospitals and critical access hospitals and plans to use the data that will be reported to enable public health interventions.

Ensuring the Safety, Effectiveness, and Availability of Products Regulated by the Food and Drug Administration

HHS's Food and Drug Administration (FDA) regulates crucial consumer products, including human and veterinary drugs, biological products, medical devices, food, cosmetics, products that emit radiation, tobacco, and infant formula. Twenty-one cents of every dollar American consumers spend goes to these FDA-regulated products. Vulnerabilities facing FDA include reliance on overseas manufacturing, increasingly complex supply chains, cyberattacks and other security risks, as well as PHE-related disruptions. While faced with these challenges, FDA must ensure the safety, effectiveness, quality, security, and availability of FDA-regulated products. FDA recently underwent a reorganization with the goal of enhancing protection of the human food supply and enabling adaptability as it regulates complex industries. Continued vigilance is needed for FDA to fulfill its role with respect to public health and ensure consumer safety.

OIG Highlighted Work

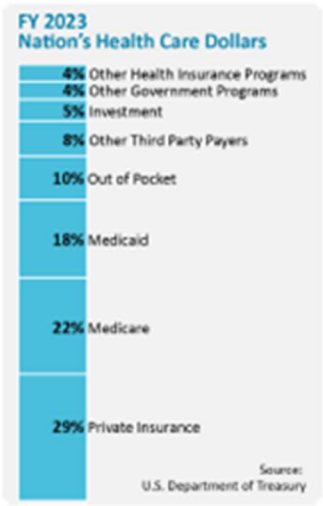
- *Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue To Be Concerns for Medicare Beneficiaries*
- *Instances of IHS Labor and Delivery Care Not Following National Clinical Guidelines or Best Practices*
- *Toolkit: Insights for Communities From OIG's Historical Work on Emergency Response*
- *The Food and Drug Administration's Foreign For-Cause Drug Inspection Program Can Be Improved To Protect the Nation's Drug Supply*
- *The Food and Drug Administration's Inspection and Recall Process Should Be Improved To Ensure the Safety of the Infant Formula Supply*

2 | Financial Integrity

Elements of the Challenge

- Preventing, reducing, and recovering improper payments
- Protecting programs from fraud, waste, and abuse
- Controlling costs by ensuring prudent payments
- Monitoring and reporting on the integrity of HHS financial management

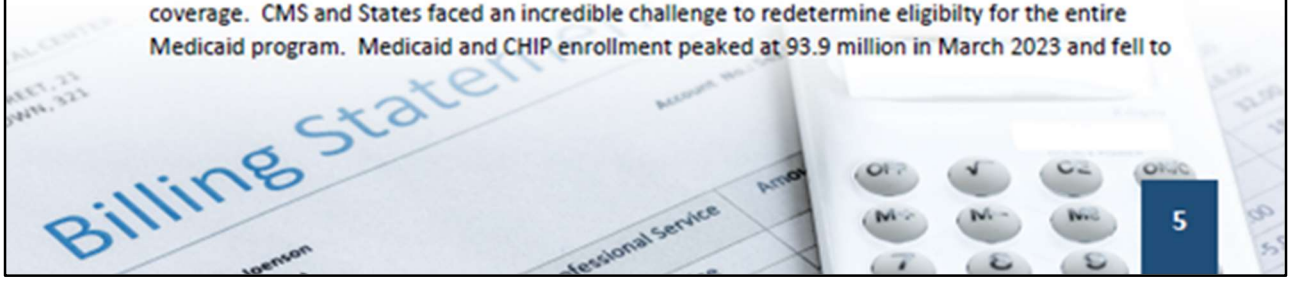
Given the $2.5 trillion in spending by HHS for fiscal year (FY) 2023 and the critical importance of the programs that HHS funds, the Department must work to ensure sound stewardship and combat fraud, waste, and abuse.



Preventing, Reducing, and Recovering Improper Payments

In FY 2023, improper payments for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) were estimated at $103.6 billion. Improper payments duplicate other payments, fund ineligible services, enrich ineligible providers, serve ineligible recipients, or violate other program rules.

- Within the Medicare fee-for-service program, reducing improper payments remains a challenge despite CMS's efforts targeting longstanding areas of concern, such as hospice, home health, hospital outpatient, and skilled nursing facility care. OIG has also identified emerging areas of concern that require attention, such as aberrantly high-billing labs; upcoded hospital stays to increase payment; genetic testing; payment for skin substitutes; and the provision of unnecessary surgical, imaging, and other procedural care.
- In the Medicaid program, HHS estimated that the FY 2023 improper payment rate was 8.58 percent of all payments. This is a decrease from 15.62 percent in FY 2022. The decrease is likely due to a combination of factors, including improved State compliance and pandemic-era protections for Medicaid coverage.
- The end of the Medicaid continuous enrollment condition on March 31, 2023, meant that states had to restart regular Medicaid renewals, which had an impact on millions of people's health insurance coverage. CMS and States faced an incredible challenge to redetermine eligibilty for the entire Medicaid program. Medicaid and CHIP enrollment peaked at 93.9 million in March 2023 and fell to



82.7 million by March 2024. Moving forward, States and CMS will have to learn from this period to continue improving eligibilty operations and avoid the high improper payment rates of the past. Key among this challenge will be CMS's work with States to ensure that massively complex State eligibilty systems work as intended to generate a higher rate of accurate eligibilty determinations.

- HHS also disburses taxpayer dollars via grants and contracts. The Department is working to modernize Grants.gov and to improve the grants management process. The Department needs to continue its progress in providing guidance and up-to-date policies to inform grant recipients on financial management, internal controls, and Federal and departmental regulations. This includes ensuring sufficient visibility into subawards of grant funds and ensuring that grants serve their intended purpose. For contracts, HHS must continue its efforts to improve the contract management and closeout processes.

Protecting Programs From Fraud, Waste, and Abuse

The Department must prevent, identify, and remedy fraud, waste, and abuse to ensure that taxpayer money serves important program goals and is not diverted for inappropriate, unauthorized, or illegal purposes. The Department must enhance oversight and internal controls to guard against fraud schemes, including embezzlement and theft. Pervasive fraud schemes, such as schemes to bill for medical equipment that is not needed or never provided, increase the need for vigilance.

Suspension and debarment programs promote integrity for Federal grants and contracts by ensuring that the Federal Government does business only with responsible entities. HHS has improved its suspension and debarment programs by offering outreach, training, and guidance to HHS awarding agencies. In addition, HHS has made technology investments to improve the tracking of cases. The Department must remain diligent in identifying bad actors and using the administrative remedy of suspenion and debarment.

Controlling Costs by Ensuring Prudent Payments

HHS must assess its payment policies, including identifying problematic policies that create perverse incentives for providers to impede patients' access to care. To the extent feasible under current law, CMS should establish prudent payment policies that control costs and promote appropriate utilization. Prescription drugs are one area in which policymakers seek to reduce spending and increase coverage. The Inflation Reduction Act of 2022 requires the Department to implement certain new authorities, including negotiating prices for certain high-expenditure Medicare drugs. The Department announced negotiated prices for the first 10 drugs selected for negotiation in August 2024. These prices will take effect in January 2026. The Department will announce up to 15 additional drugs covered under Part D for the next cycle of negotiations by February 2025.

Monitoring and Reporting on the Integrity of HHS Financial Management

The Department has taken steps to improve its information technology controls within its financial systems, including establishing a governance body over the systems that support financial reporting activities. This has led to improvements in its core financial systems. However, deficiencies persist in internal controls over system access. The Department must take additional actions to address and resolve these issues, including continuing efforts to monitor access to key applications and ensuring appropriate segregation of duties.

OIG Highlighted Work

- *CMS's Oversight of Medicare Payments for the Highest Paid Molecular Pathology Genetic Test Was Not Adequate To Reduce the Risk of up to $888 Million in Improper Payments*
- *Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths*
- *UPICs Hold Promise To Enhance Program Integrity Across Medicare and Medicaid, but Challenges Remain*
- *NIH Did Not Consistently Meet Federal Single Audit Requirements for Extramural Grants*
- *Technical Assistance Brief: Implementation of Inflation-Indexed Rebates for Part B Drugs*
- *HRSA Made Some Potential Overpayments to Providers Under the Phase 2 General Distribution of the Provider Relief Fund Program*
- *Medicare Remains Vulnerable to Fraud, Waste, and Abuse Related to Off-the-Shelf Orthotic Braces, Which May Result in Improper Payments and Impact the Health of Enrollees*

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3 | Medicare and Medicaid

Elements of the Challenge

- Combating fraud, waste, and abuse
- Improving quality and safety in nursing homes
- Strengthening oversight of managed care programs
- Fostering equitable access to high-quality care

More than 147 million American seniors, individuals with disabilities, people in low-income households, and individuals with end-stage renal disease and other complex health needs rely on Medicare and Medicaid, so HHS must ensure that these programs deliver high-quality care and reduce disparate outcomes and barriers to access.

Combating Fraud, Waste, and Abuse

Minimizing fraud, waste, and abuse is critical to helping Medicare and Medicaid programs deliver quality care to enrollees and value to taxpayers. HHS must focus on fraud prevention (e.g., provider enrollment screening and revalidation), detection (e.g., claims and other data analysis), and enforcement to recover misspent funds, protect patients from harm, and hold wrongdoers accountable. CMS has demonstrated successful coordination with law enforcement to prevent payments to fraudulent billers. CMS should continue to expand upon this prepayment suspension mechanism where appropriate. The Department must remain vigilant to protect Medicare and Medicaid programs from fraud, waste, and abuse across all service and provider types, especially in high-risk areas, such as durable medical equipment, home health, hospice, genetic and clinical laboratory testing, treatment for substance use disorder, and medical identity theft. Different CMS programs (e.g., managed care, traditional Medicare, value-based care models) have different risks because they pay for services and provide coverage differently. As HHS refines payment policies and incentives, it must anticipate and guard against exploitation of specific payment designs.

Improving Quality and Safety in Nursing Homes

Nursing home residents deserve safe, high-quality care, yet improving nursing homes remains one of the most complex and intransigent challenges facing the American health care system. The unprecedented COVID-19 pandemic posed novel challenges for nursing home staff, residents, and families, and highlighted longstanding problems in areas such as emergency preparedness and infection control; staffing shortages; frontline oversight by CMS and State survey agencies; and health disparities based on race, ethnicity, and geography.

HHS has taken important steps to improve nursing home performance by promoting transparency of facility ownership and staffing adequacy, including publishing a final rule defining minimum staffing standards, and must continue to build on this progress. The Department must ensure that taxpayer funds are spent appropriately to meet the needs of residents. The Department must also continue to take meaningful steps to foster safe, high-quality, dignified care for residents in areas such as emergency preparedness and infection control, misuse of drugs, facility-initiated discharges, and preventing abuse and neglect. Finally, the Department must remain attentive to strengthening the effectiveness of State survey agency performance and the response to poor-performing nursing homes. Improving nursing home care will require partnerships and sustained commitment from Government and private stakeholders to achieve positive change.

Strengthening Oversight of Managed Care Programs

As managed care continues to expand, now covering more than half of Medicare enrollees and more than 80 percent of Medicaid enrollees, HHS must ensure that managed care operates effectively and efficiently. HHS must continue to strengthen protections against Medicare Advantage organizations inappropriately claiming additional risk adjustment payments by making their enrollees appear sicker than they might be. CMS must also improve its oversight of Medicare and Medicaid managed care to reduce inappropriate prior authorization and payment denials that prioritize reducing plan costs over enrollees' health. CMS has taken steps to increase transparency for Medicare enrollees about Medicare Advantage organizations' prior authorization and coverage decisions, and rigorous oversight will continue to be needed to ensure that enrollees receive appropriate care without undue administrative or financial burden. Other key risk areas requiring continued attention include curbing misleading and deceptive marketing by managed care plans and ensuring that States have needed data to prevent duplicate Medicaid managed care capitation payments between States and to prevent Medicaid managed care capitation payments for deceased beneficiaries.

Fostering Equitable Access to High-Quality Care

Disparities in access, quality of care, and health outcomes persist for Medicare and Medicaid enrollees in certain geographic areas, members of some racial and ethnic groups, and individuals with intellectual and physical disabilities. During the COVID-19 PHE, Congress temporarily expanded access to telehealth for Medicare enrollees, resulting in a dramatic increase in telehealth services. However, telehealth use varied

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greatly among enrollees in different geographic areas and among certain demographic groups. As the Department implements new telehealth policies with an eye toward improved access, quality of care, and health equity, it must also balance program integrity, privacy, and security demands. As HHS works to reduce health disparities, it must improve the accuracy of relevant data to help measure and facilitate progress in reducing disparities. Further, the Department must take steps to ensure compliance with mental health and substance use disorder parity requirements.

OIG Highlighted Work

- *Oversight of Managed Care for Medicare and Medicaid*
- *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*
- *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*
- *Lessons Learned During the Pandemic Can Help Improve Care in Nursing Homes*
- *Florida Ensured That Nursing Homes Complied With Federal Background Check Requirements*
- *CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements*

4 | Beneficiary Safety

Elements of the Challenge

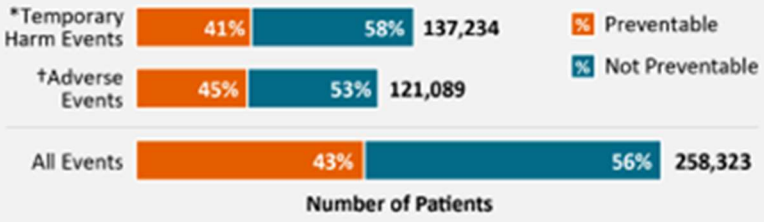
- Ensuring safety and quality in Federal health care programs
- Protecting the health and safety of children
- Preventing abuse and neglect

HHS programs provide and fund critical health care, child care, and educational services for diverse populations in hospitals, clinics, child care facilities, shelters, nursing homes, and people's own homes. Ensuring that intended beneficiaries receive appropriate services that meet standards for quality, are free from abuse or neglect, and do not experience preventable harm represents a major challenge for the Department.

Ensuring Safety and Quality in Federal Health Care Programs

Federal health care programs must deliver care that meets quality and safety standards and that intended beneficiaries can access without undue burden or disparities. Although HHS has made progress, more work remains to improve access to and quality of all types of care. Too often, health care results in patient harm, such as adverse events and temporary harm events, much of which is preventable.

Patient Harm Events:
OIG Analysis of Hospital Stays for Medicare Patients in October 2018



Source: OIG analysis of hospital stays for Medicare patients in October 2018 using medical record review of a simple random sample of 770 patients.

* The rate and projected number of patients who experienced temporary harm events involve patients who experienced at least one temporary harm event and no adverse events.

† The rate and projected number of patients who experienced adverse events involve patients who experienced at least one adverse event. Thirty-four percent of patients (41,708) in this group also experienced temporary harm.

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Protecting the Health and Safety of Children

In addition to health care, HHS operates or funds programs that provide child care, education, and residential care to many children, such as children living in foster care and children in the Unaccompanied Children (UC) Program. The Administration for Children and Families should work with States to increase compliance with Federal requirements to protect children in foster care from human trafficking.

For unaccompanied children in the care of the Office of Refugee Resettlement (ORR), the Department must ensure that UC Program-funded facilities meet all health and safety requirements and provide adequate medical and mental health care. HHS must continue to enhance efforts to ensure that all individuals with access to children have been screened appropriately and passed required background checks. HHS has taken steps to enhance its screening of sponsors applying to care for unaccompanied children upon their release from ORR care. These include producing guidance to assist staff with screening sponsors and determining whether to conduct a study of the sponsor's home. HHS's continued vigilance is needed to meet its goal of limiting children's time in care while ensuring safe and appropriate release to vetted sponsors. The Department of Homeland Security's challenges monitoring the location and status of unaccompanied children released to sponsors and difficulties notifying HHS when unaccompanied children fail to appear for immigration procedures highlight the importance of thorough front-end sponsor vetting.

Preventing Abuse and Neglect

Thousands of HHS-funded providers hold positions of trust that bring them into close contact with individuals, often behind closed doors and at especially vulnerable times. Most providers earn this trust and work hard to serve people well. However, some providers harm people, and the Department must better protect those enrolled in its programs from abuse and neglect. The Indian Health Service (IHS) initiated measures to protect patients from sexual predators after an IHS pediatrician went to prison for sexually assaulting boys he treated as patients. The IHS's actions include improved monitoring, tracking, and auditing procedures for staff background checks, and improved communication with tribally operated facilities when workers are temporarily assigned. These measures reflect meaningful progress, but better attention to protecting people of all ages at risk for abuse and neglect in all care settings is needed.

Thoroughly vetting providers and staff by using background checks helps prevent potential predators from gaining access to victims in Federal programs. The Department must ensure adequate background checks in HHS-funded child care programs and health care settings.

Although awareness may be highest in pediatric settings and nursing homes, people in all care settings are at risk of abuse and neglect. Identifying and reporting abuse and neglect is important but may be particularly challenging in nonfacility settings, such as home- and community-based services or group homes. Mandatory reporting laws require certain professionals, such as teachers or nursing home staff, to report suspected abuse or neglect. The Agency for Community Living operates the National Adult Maltreatment Reporting System to support Adult Protective Services that address adult maltreatment in all States, but more must be done to help victims and hold wrongdoers accountable. Periodic inspections and safety checks as well as education to encourage reporting and appropriate vehicles to facilitate reporting can further protect people from abuse and neglect.

States and other partners should use claims data to better identify unreported abuse and neglect, and CMS should compile a list of diagnosis codes that indicate potential abuse or neglect, conduct periodic data extracts, and encourage States to better use data to facilitate compliance with mandatory reporting laws. CMS should ensure that its reporting requirements sufficiently protect individuals in all care settings and are adequately enforced. Protecting people from abuse and neglect is a critical responsibility that requires attention and cooperation from all stakeholders.

OIG Highlighted Work

- *Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018*
- *Toolkit: Insights from OIG's Work on the Office of Refugee Resettlement's Efforts To Care for Unaccompanied Children*
- *Medicaid Data Can Be Used To Identify Instances of Potential Child Abuse or Neglect*
- *Many States Lack Information To Monitor Maltreatment in Residential Facilities for Children in Foster Care*
- *In Five States, There Was No Evidence That Many Children in Foster Care Had a Screening for Sex Trafficking When They Returned After Going Missing*
- *A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect*

5 | Data and Technology Security

Element of the Challenge

- Improving cybersecurity for HHS programs, related industry sectors, and individuals

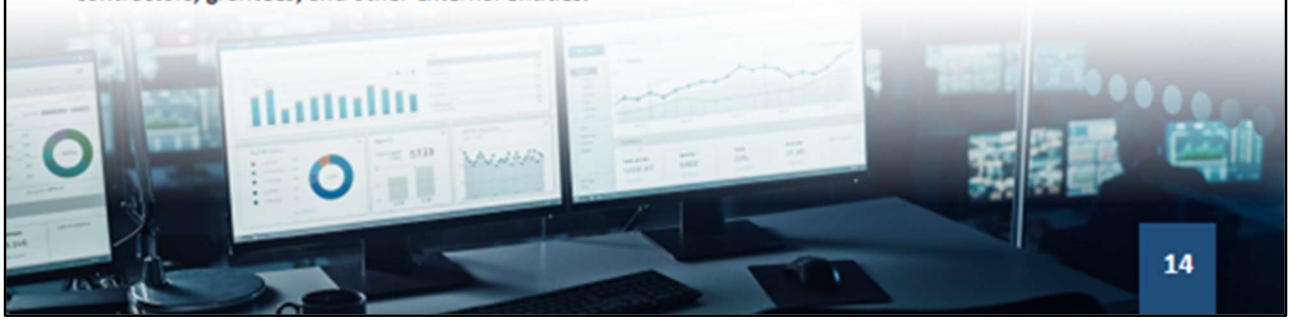
HHS faces persistent cybersecurity threats that exacerbate the challenges associated with data and technologies used to carry out the Department's vital health and human services missions. The large scale of HHS's mission and information technology environments requires that the Department simultaneously address a range of cybersecurity risks along with the specific data and technology needs for each HHS agency and program.

HHS must adapt as risks expand to include social engineering threats, data breaches, and increasingly sophisticated cyberattacks.

Improving Cybersecurity for HHS Programs, Related Industry Sectors, and Individuals

Cyberattacks and related threats can imperil critical HHS operations and programs, potentially compromising the health and welfare of the individuals HHS serves. Disparate organizational approaches to cybersecurity that vary by agency and program within the Department and across the Government complicate HHS's preparedness efforts to prevent or respond to cybersecurity risks. Improving cybersecurity posture requires significant resource investments and cultural and organizational change across HHS. The Department must ensure that its agencies and programs employ a risk-based approach to identifying and implementing information system security solutions to protect technology and data. For example, mitigating threats that target HHS for financial gain, such as fraud schemes attempting to exploit Government payment systems, requires clear communication across HHS. The Department is taking steps to improve cybersecurity, but progress is often dependent on each agency and program.

Comprehensive cybersecurity solutions must be implemented not just within the Department but also by the thousands of HHS contractors, grantees, and other external entities. For many HHS programs, effective cybersecurity will depend on these parties implementing comprehensive security solutions that mitigate cyber threats specific to their operations, which may be more challenging for smaller entities. Protecting technology and data also requires broader efforts beyond implementing technical cybersecurity fixes, such as establishing clear expectations; modernizing program rules; and conducting effective oversight of the Department's contractors, grantees, and other external entities.



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HHS must also help address significant cybersecurity threats for the industries and other entities it oversees. The health care industry remains a prime target for cyberattacks, as demonstrated by the cyberattack on Change Healthcare. Bad actors continue to leverage the threat of interrupting patient care and other critical health care operations to extract ransoms or other value from health care providers and other entities that play a vital role in the health care industry. The diffuse nature of HHS cybersecurity authorities and responsibilities complicates response efforts. Some HHS agencies have limited authority or expertise to address cybersecurity risks affecting the industries and other entities they oversee. Besides HHS, other Federal entities and departments, such as Federal law enforcement and the Department of Homeland Security Cybersecurity and Infrastructure Security Agency, play a significant role in addressing cybersecurity threats, adding coordination and communication challenges.

The Department leads a network of Federal agencies to improve the cybersecurity of the health care and public health sectors. Although HHS has employed public-private partnerships to improve threat communication with industry partners, challenges remain that the Department has limited authorities or resources to address, including the industry's reliance on legacy technology and workforce challenges. As cybersecurity threats and potential targets increase, HHS must maintain vigilance, expeditiously notify the sector of vulnerabilities, and help the health care industry adapt to evolving threats.

The Department must also work to protect the privacy of sensitive individual data replete throughout the health care system. HHS's ability to enforce the decades-old Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and HIPAA Security Rule may not be sufficient to address contemporary privacy concerns or changes in how patient information is collected and used. Working within the statutory authorities established by HIPAA in 1996, the Department must adapt as privacy and security needs evolve and provide guidance for patients and providers.

OIG Highlighted Work

- *NIH Generally Implemented System Controls Over the Sequence Read Archive but Some Improvements Needed*
- *Alabama MMIS and E&E System Security Controls Were Adequate, but Some Improvements Are Needed*
- *ACF Has Enhanced Some Cybersecurity Controls Over the Unaccompanied Children Portal and Data, but Improvements Are Needed*
- *Illinois MMIS and E&E System Had Adequate Security Controls in Place, but Some Improvements Are Needed*

Conclusion

Careful attention to these top management challenges will help the Department achieve its crucial mission to manage taxpayer dollars responsibly, safeguard public health, and deliver high-quality care and services.

Stay in Touch

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Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Department of Health and Human Services
Office of Inspector General

Department's Response to the Office of Inspector General

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Deputy Secretary

To: Christi A. Grimm, Inspector General

From: Andrea Palm, Deputy Secretary

Subject: Fiscal Year 2024 Top Management and Performance Challenges Facing HHS

We appreciate the Office of Inspector General's (OIG) work in identifying key management and performance challenges at the Department of Health and Human Services (HHS). The OIG's audits and investigations help improve HHS operations, benefitting both our stakeholders and the people who depend on HHS to enhance their health and well-being.

We are committed to addressing these challenges and other key issues facing the Department and appreciate the OIG's recommendations in these five areas. With the support of our talented workforce, we will continue to innovate in areas like public health, beneficiary safety, data security, technology, and protecting program operations and financial integrity to better support HHS's critical functions.

We look forward to continuing our work with the OIG as we strive to improve the health and well-being of those we serve through sound financial management and improvements to program operations.

/Andrea Palm/

Andrea Palm
Deputy Secretary
November 14, 2024

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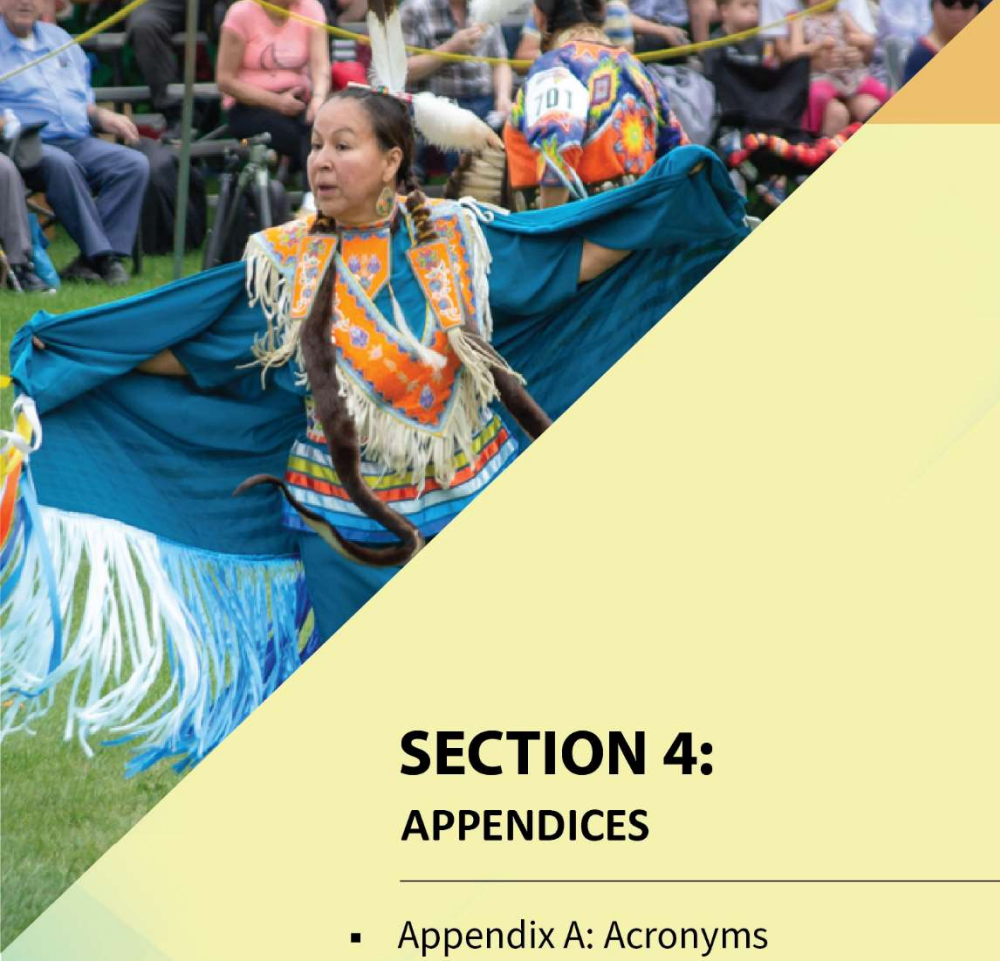

SECTION 4:
APPENDICES

- Appendix A: Acronyms
- Appendix B: Connect with HHS

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Appendix A: Acronyms

AAP	Accelerated and Advance Payment
ACF	Administration for Children and Families
ACL	Administration for Community Living
ADA	*Antideficiency Act*
AFR	Agency Financial Report
AHRQ	Agency for Healthcare Research and Quality
APG	Agency Priority Goal
APTC	Advance Premium Tax Credit
ARP	*American Rescue Plan Act of 2021*
ASFR	Office of the Assistant Secretary for Financial Resources
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE	Office of the Assistant Secretary for Planning and Evaluation
ASPR	Administration for Strategic Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
BARDA	Biomedical Advanced Research and Development Authority
CAAP	COVID-19 Accelerated & Advance Payment
CAP	Corrective Action Plan
CARES Act	*Coronavirus Aid, Relief, and Economic Security Act*
CCDF	Child Care and Development Fund
CCWIS	Comprehensive Child Welfare Information System
CDC	Centers for Disease Control and Prevention
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CIO	Chief Information Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
COFFA	Council on Federal Financial Assistance
COLA	Cost of Living Adjustment
COVID-19	Coronavirus Disease
CPI	Consumer Price Index
CRC	Commercial Repayment Center
CSRS	Civil Service Retirement System
CX	Customer Experience
CY	Calendar year
DAB	Departmental Appeals Board
DATA Act	*Digital Accountability and Transparency Act of 2014*
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMF	Death Master File
DNP	Do Not Pay
DOI	Department of the Interior
DOL	Department of Labor
DRA	*Deficit Reduction Act of 2005*
E-Invoicing	Electronic Invoicing
EIS	Enterprise Infrastructure Solutions
EPMO	Enterprise Program Management Office
ERM	Enterprise Risk Management
FASAB	Federal Accounting Standards Advisory Board
FBIS	Financial Business Intelligence System
FBwT	Fund Balance with Treasury
FDA	Food and Drug Administration
FECA	*Federal Employees' Compensation Act*
FERS	Federal Employees Retirement System
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFS	Fee-For-Service
FGB	Financial Management Governance Board
FICA	*Federal Insurance Contributions Act*
FIFO	First-In/First-Out
Fin Ops	Financial Operations
FITARA	*Federal Information Technology Acquisition Reform Act*
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FR	Financial Report of the United States Government
FRA	*Fiscal Responsibility Act of 2023*
FSCE	Financial Systems Control Environment
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	U.S. Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
G-Invoicing	Government Invoicing
Grants QSMO	Grants Quality Service Management Office
GSA	General Services Administration
GTAS	Governmentwide Treasury Account Symbol Adjusted Trial Balance System
HCC	Hierarchical Condition Category
HEW	Department of Health, Education, and Welfare
HHS	Department of Health and Human Services
HI	Hospital Insurance

Acronyms

HIPAA	*Health Insurance Portability and Accountability Act of 1996*
HMO	Health maintenance organizations
HRSA	Health Resources and Services Administration
IBNR	Incurred But Not Reported
IGT	intra-governmental
IHS	Indian Health Service
I-MEDIC	Investigations Medicare Drug Integrity Contractor
IP	Improper Payments
IRA	*Inflation Reduction Act*
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
IT	Information Technology
LIHEAP	Low-Income Home Energy Assistance Program
LIHWAP	Low-Income Household Drinking Water and Wastewater Emergency Assistance Program
LPR	Lawful Permanent Resident
MA	Medicare Advantage
MACs	Medicare Administrative Contractors
MAF	Management Assessment Framework
MAO	Medicare Advantage Organization
MCO	Medicaid Managed Care Organization
MDH	Medicare-Dependent Hospital
MEDIC	Medicare Drug Integrity Contractor
MEQC	Medicaid Eligibility Quality Control
MIPS	Merit-based Incentive Payment System
MSP	Medicare Secondary Payer
NAIC	National Association of Insurance Commissioners
NBS	National Institutes of Health Business System
Net PTC	Net Premium Tax Credits
NIH	National Institutes of Health
OASDI	Old-Age, Survivors, and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCIO	Office of the Chief Information Officer
OCR	Office for Civil Rights
OGA	Office of Global Affairs
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OpDiv	Operating Division
OPM	Office of Personnel Management
OS	Office of the Secretary
PACE	Program of All-Inclusive Care for the Elderly
Part A	Hospital Insurance
Part B	Medical Insurance
Part C	Medicare Advantage
Part D	Medicare Prescription Drug Benefit
PDE	Prescription Drug Event
PHE	Public Health Emergency
PHS Act	*Public Health Service Act*
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PIIA	*Payment Integrity Information Act of 2019*
POP	Period of Performance
PP	Proper Payments
PP&E	Property, Plant and Equipment
PPACA	*Patient Protection and Affordable Care Act*
PPEO	Provisional Period of Enhanced Oversight
PPI	Plan Program Integrity
PRAC	Pandemic Response Accountability Committee
PRF	Provider Relief Fund
PSA	Public Service Announcement
PSC	Program Support Center
RAC	Recovery Auditor Contractor
RADV	Risk Adjustment Data Validation
REMS	Risk evaluation and mitigation
RSI	Required Supplementary Information
RY	Reporting Year
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSIA	Statement of Changes in Social Insurance Amounts
SECA	*Self-Employment Contribution Act*
SFFAS	Statement of Federal Financial Accounting Standards
SMI	Supplementary Medical Insurance
SMRC	Supplemental Medical Review Contractor
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSF	Service and Supply Funds
StaffDiv	Staff Division
STLT	State, Tribal, Local, and Territorial
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TAS	Treasury Account Symbol
The 2015 Act	*Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015*
Treasury	U.S. Department of the Treasury
TTD	Time-to-Death
U.S.	United States
U.S.C.	United States Code

Acronyms

UIP	Uninsured Program
UP	Unknown Payments
UPIC	Unified Program Integrity Contractors
USPS	United States Postal Service
USSGL	United States Standard General Ledger
VFC	Vaccines for Children

Appendix B: Connect with HHS

On behalf of the Department, we sincerely thank and acknowledge all the individuals who provided support, either through content contribution or review feedback, to produce the FY 2024 Agency Financial Report. We could not have prepared this year's report without the talent and dedication of employees across the Department.

Electronic copies and prior years' reports are available through the Department's website. We welcome your comments on how we can make this report more informative. Please send your comments to the following address or connect with us via social media:

United States Department of Health and Human Services
Office of Finance/Office of Financial Reporting and Policy
Mail Stop 549D
200 Independence Avenue, S.W.
Washington, D.C. 20201

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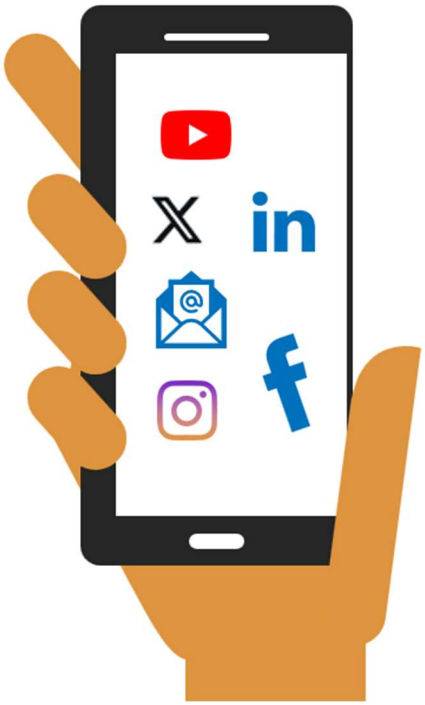

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

200 Independence Ave, S.W. ● Washington, D.C. 20201

877.696.6775 ● www.hhs.gov