DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FINANCIAL REPORT

FISCAL ACCOUNTABILITY FOR A HEALTHY AMERICA

FISCAL YEAR 2025

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 for 12 consecutive years through the Certificate of Excellence in Accountability Reporting Program. The Certificate of Excellence in Accountability Reporting Program was established in collaboration with the Chief Financial Officers 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 2024 Agency Financial Report exemplifies our dedication, spirit, and commitment to the HHS mission. HHS's perseverance and efforts in FY 2024 continue to demonstrate award-winning results. Thank you to everyone at HHS for making this possible.

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MESSAGE FROM THE SECRETARY

When I accepted the responsibility of serving as Secretary of Health and Human Services (HHS), I did so with a clear mission: to restore integrity, transparency, and trust in our mission. Diligent fiscal responsibility and accountability are necessary to upholding those tenets.

Fiscal 2025 was a year of transformation. Our efforts were not cosmetic or marginal; they were foundational. We've set in motion a cultural shift across the Department that focuses on:

- Ending the chronic disease epidemic and prioritizing prevention.
- Leading initiatives to empower everyday Americans to create better health outcomes.
- Being radically transparent with research and processes.
- Combating waste, fraud, and abuse.
- Restoring gold-standard science.

HHS is the steward of our nation's health care system and the taxpayer dollars that power it. A deep appreciation of this fact guides our work and ensures that the resources entrusted to us are used wisely, responsibly, and—above all—effectively.

ENDING THE CHRONIC DISEASE EPIDEMIC & PRIORITIZING PREVENTION

Chronic disease is a national crisis. It accounts for over 70% of health care spending and one-third of the federal budget—only for our country to rank last in terms of health among developed nations. For decades, our national health policy has treated chronic disease as inevitable. We do not accept that. For too long, America has operated within a sick-care system, one in which patients fell ill before they received attention. The new HHS aims to transform that model into a true health care system that emphasizes good nutrition, promotes physical activity, and provides people with the tools they need to live well and achieve their full potential.

By raising public consciousness of the role of processed foods in fueling chronic diseases like diabetes, we hope to inspire Americans to become more mindful in their meal choices and take greater personal responsibility for their wellness—all with the goal of driving measurable improvements in chronic disease prevention and national health outcomes.

RADICAL TRANSPARENCY

Our health care system needs reform, and it starts with being radically transparent. Our citizens deserve to know how health decisions are made, who is influencing them, and what evidence is—or isn't—behind the policies that affect their lives. It applies to the grants we award, the research we fund, and the contracts we sign. It includes the rules our programs establish to ensure Americans know what is in their food, vaccines, and pharmaceuticals. It comprises our data, information, and policy processes. We've also reformed the Prior Authorization system—long criticized for delays and opacity. Working with payers, we've implemented new digital standards that reduce friction while increasing accountability. Transparency is not just good governance; it is a prerequisite for public trust.

COMBATING WASTE, FRAUD & ABUSE

Earned trust also calls for combating waste, fraud, and abuse in the health care system. Thanks to President Trump signing into law the *Working Families Tax Cut* (WFTC) legislation on July 4th, HHS can better ensure resources are spent on qualified individuals while reducing improper payments. The WFTC calls for strengthening premium tax credit verifications for qualified health plans through recurring and rigorous recipient income and eligibility checks. For Medicaid, the Centers for Medicare & Medicaid Services (CMS) will establish new checks and balances to discourage eligibility fraud and duplicate claims, improve enrollment integrity, and reduce the program's improper payments. CMS now has new tools to prevent the federal government from paying twice for the same person's care, potentially saving taxpayers up to $14 billion annually. Every dollar wasted in health care is a dollar that could have helped a patient in need.

GOLD STANDARD SCIENCE

Science must be free from manipulation, immune to political pressure, and centered on truth—wherever it leads. HHS has and will continue to implement President Trump's Executive Order, "Restoring Gold Standard Science," through rigor, reproducibility, objectivity, integrity, full transparency, and other key tenets. Our culture, funding opportunities, research, grants, and operating budget will reflect these core principles. The National Institutes of Health have already taken steps on this paradigm shift through the development of the next-generation universal vaccine platform, Generation Gold Standard. Vaccine development and all innovation at HHS must be grounded in the highest levels of safety and efficacy testing.

STEWARDSHIP

HHS maintains a comprehensive, sound system of management controls to ensure fiscal accountability of American taxpayers. For the 27th consecutive year, we obtained an unmodified (clean) opinion on our Fiscal 2025 Consolidated Balance Sheet, Statement 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 2025 Medicare Trustees Report. The "Financial Section" of this report 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 of this report includes further details.

CONCLUSION

We do not underestimate the challenge before us, but neither do we shy from it. This has been a year of action, awakening, and renewal. But this is only the beginning. The task ahead is immense—but so is the power of people once they are informed, inspired, and unafraid.

To our civil servants, frontline responders, researchers, doctors, nurses, and patients: You are the beating heart of this transformation.

Thank you for walking this path with us as we achieve President Trump's vision to Make America Healthy Again.

With gratitude and determination,

/Robert F. Kennedy, Jr./

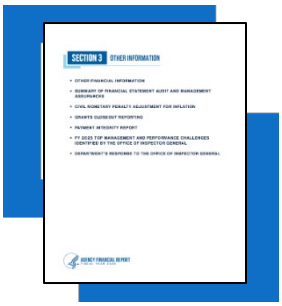
Robert F. Kennedy, Jr.
Secretary
January 14, 2026

About the Agency Financial Report

The Department of Health and Human Services fiscal year FY 2025 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, 2024,through September 30, 2025. 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, and program performance. 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 2026 including the FY 2027 *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
- SYSTEMS, LEGAL COMPLIANCE, AND INTERNAL CONTROL
- MANAGEMENT ASSURANCES
- FINANCIAL SUMMARY AND HIGHLIGHTS

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OUR MISSION

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.

WHO WE ARE

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.

WHAT WE DO

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 12 Operating Divisions (Divisions) 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 (Divisions) within OS provide leadership, direction, and policy and management guidance to the Department. 10 Divisions are components of the U.S. Public Health Service.

Through its programs and partnerships, HHS's priorities are:

- Addressing the chronic disease epidemic;
- Empowering patients to make informed decisions about health care;
- Preventing conflicts of interest and achieving gold standard science;
- Exploring alternative testing models;
- Furthering our understanding of autism;
- Protecting children and families from toxins;
- Advancing scientific understanding of the aging process;
- Using digital tools and artificial intelligence to improve health, while maintaining data privacy;
- Strengthening the health care workforce and promoting patient safety; and
- Ending dangerous gain-of-function research.

About the Department of Health and Human Services

Organizational Structure

Led by the HHS Secretary, OS establishes the overarching vision and strategic direction for the Department and its Divisions to provide a wide range of services and benefits for the American people. For more information on HHS's organizational structure, refer to HHS's website.

Each Operating Division contributes to the HHS mission as follows:

Administration for Children and Families (ACF)	ACF's mission is to foster health and well-being through federal leadership, partnerships, and resources for the compassionate and effective delivery of human services. ACF promotes the economic and social well-being of children, youth, families, individuals, and communities by emphasizing resilience, safety, and economic security through strategic, results-driven programs in collaboration with states, tribes, and community organizations.
Administration for Community Living (ACL)	ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. Through partnerships with community-based organizations and investments in research, education, and innovation, ACL works to ensure that people of all ages with disabilities can live where and with whom they choose, fully participating in their communities.
Agency for Healthcare Research and Quality (AHRQ)	AHRQ's mission is to enhance the quality, appropriateness, effectiveness, and accessibility of health services through scientific research and the promotion of improvements in clinical and health system practices, including disease prevention. AHRQ works within HHS and with states, territories, tribal nations, and private partners to ensure evidence is understood, used, and aligned with national priorities.
Advanced Research Projects Agency for Health (ARPA-H)	ARPA-H's mission is to accelerate better health outcomes for everyone by supporting high-impact, high-risk research that tackles society's most challenging health problems. With a scope from the molecular to the societal, ARPA-H drives transformative biomedical and health breakthroughs through innovative, nimble, and inclusive program design, ensuring access to solutions regardless of demographics or geography.
Administration for Strategic Preparedness and Response (ASPR)	ASPR's mission is to lead the nation's medical and public health preparedness for, response to, and recovery from disasters and other public health emergencies. ASPR collaborates with healthcare systems, government partners, and communities to improve readiness, deploy clinical response teams, manage critical response tools, and strengthen national health security against current and emerging threats.

About the Department of Health and Human Services

Agency for Toxic Substances and Disease Registry (ATSDR)	ATSDR's mission is to protect communities from harmful exposures to hazardous substances. ATSDR fulfills this mission by responding to environmental health emergencies, investigating threats, conducting research on hazardous waste impacts, and providing science-based guidance to state and local health partners.
Centers for Disease Control and Prevention (CDC)	CDC's mission is to protect the health, safety, and security of Americans by preventing and responding to public health threats, both domestic and global. CDC advances health through science, technology, and innovation; provides timely, evidence-based guidance; and strengthens public health systems to ensure rapid, transparent, and effective responses to emerging challenges.
Centers for Medicare & Medicaid Services (CMS)	CMS's mission is to ensure the most vulnerable receive high-value care by leading all payors and supporting providers. CMS collaborates across the health system to improve care quality, promote health equity, and drive innovation. CMS also manages one of the largest collections of health care data in the country, using it to inform evidence-based policy and system-wide improvements.
Food and Drug Administration (FDA)	FDA's mission is to protect public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices, as well as the safety of the nation's food supply, cosmetics, dietary supplements, radiation-emitting products, and tobacco. FDA advances health by accelerating innovation, supporting the development of medical products, and providing science-based information to help the public make informed decisions and respond to both routine and emerging health threats.
Health Resources and Services Administration (HRSA)	HRSA's mission is to improve health outcomes through access to quality services, a skilled health workforce, and innovative, high-value programs. HRSA also strengthens the health care infrastructure by supporting workforce training, expanding telehealth, funding community health centers, and managing programs such as organ donation, vaccine injury compensation, and prescription drug discounts.
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. The IHS vision is a health system that embraces traditional knowledge and practices to foster thriving communities for seven generations. As the principal federal health care provider for American Indians and Alaska Natives, IHS delivers comprehensive health services to approximately 2.8 million individuals from 574 federally recognized tribes across 37 states.

About the Department of Health and Human Services

National Institutes of Health (NIH)	NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and to the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. NIH fosters creative discoveries and innovative research strategies, supports the development of scientific resources, and promotes the highest standards of scientific integrity and public accountability. NIH leads and funds research across a wide range of health areas to improve the health of the nation and ensure a strong return on public investment.
Substance Abuse and Mental Health Services Administration (SAMHSA)	SAMHSA's mission is to lead public health and service delivery efforts that treat mental illness, prevent substance misuse and addiction, and provide treatments and supports that foster recovery while ensuring access and better outcomes for all. SAMHSA advances the behavioral health of the nation by addressing co-occurring disorders, expanding crisis care, improving access to evidence-based treatment, and helping individuals achieve long-term recovery.

The following Staff Divisions within OS support the Operating Divisions in carrying out the Department's mission:

Assistant Secretary for Administration (ASA)	ASA provides leadership for HHS departmental administration, including human resource policy, information technology (IT), and departmental operations. The Program Support Center, a component of ASA, is a shared services provider that helps organizations meet their needs.
Office of Assistant Secretary for Financial Resources (ASFR)	ASFR provides advice and guidance to the HHS Secretary on all aspects of budget, financial management, grants management, acquisition management, and 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.
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.

About the Department of Health and Human Services

Office of the Assistant Secretary for Planning and Evaluation (ASPE) 	ASPE advises the Secretary on policy development and is responsible for major activities in policy coordination and research, strategic planning, legislative development, evaluation, and economic analysis.
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 Divisions and regional health offices. ASPA manages the Department's digital communications, administers the Freedom of Information and Privacy Acts, and leads the planning, development, and implementation of emergency incident communications strategies and activities for the Department.
Office for Civil Rights (OCR) 	OCR enforces federal civil rights laws, conscience and religious freedom laws, the *Health Insurance Portability and Accountability Act* Privacy, Security, and Breach Notification Rules, and the *Patient Safety Act and Rule* to protect fundamental rights of nondiscrimination, conscience, religious freedom, and health information privacy.
Departmental Appeals Board (DAB) 	DAB provides impartial and independent review of disputed decisions under 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.
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 the development and implementation of 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.

About the Department of Health and Human Services

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.
Office of Medicare Hearings and Appeals (OMHA) 	OMHA administers nationwide hearings for appeals arising from individual claims for Medicare coverage and payment for items and services furnished to beneficiaries (or enrollees) under Medicare Parts A, B, C, and D. OMHA also hears appeals arising from claims for entitlement to Medicare benefits and disputes of Medicare Medical Insurance (Part B) and Medicare Prescription Drug Benefit (Part D) premium surcharges.
Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) 	ASTP/ONC develops and oversees the implementation of HHS's data, technology, interoperability, and artificial intelligence (AI) strategies and policies. ASTP/ONC is committed to ensuring that HHS's data and technology programs, policies, and investments are well coordinated and aligned to advance HHS's mission.
Office of the Chief Information Officer (OCIO) 	OCIO 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

HHS Performance Management Framework

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 HHS Divisions and leadership to monitor progress toward achieving key performance objectives;
- Identifying and setting performance measures to support the achievement of the HHS Strategic Plan and Division budget requests; aiming to achieve 70 to 75 percent of performance improvements;
- Conducting strategic reviews to support decision-making and performance improvement;
- Coordinating performance measurement, budgeting, strategic planning, and evidence-building activities within the Department;
- Fostering a network of Performance Officers who support, coordinate, and implement performance management efforts across HHS; and
- Sharing performance management best practices through webinars and other media.

Data Quality

HHS follows *GPRA Modernization Act of 2010* guidelines for reporting and improving performance data quality as one type of evidence used in policymaking 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.

Divisions certify their data quality on an annual basis for all publicly reported measures, 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 Division 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 *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.

Performance Goals, Objectives, and Results

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 Department's Divisions contribute to the development and successful execution of the HHS Strategic Plan.

The HHS Strategic Plan FY 2026 – 2030 is scheduled for publication in March 2026. HHS will align its focus, strategies, and activities to achieve these strategic goals and objectives.

Agency Priority Goals

APGs are a set of ambitious and realistic performance objectives the Department expects to achieve within a 24-month period. APGs include performance measure reporting to track progress and represent how the Department meets its mission. APG results rely on agency implementation and do not require new legislation or additional funding since they align with existing budget levels.

HHS concluded public reporting on the FY 2024 – 2025 APGs with the FY 2024 Quarter 4 update, published in January 2025.

Advancing Customer Experience

In FY 2024, HHS made significant progress on its Customer Experience (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 13 Operating Divisions aimed at improving the ease of use of services for customers. Each Operating Division conducted assessments of their CX capabilities, identified key customers, and developed plans for improving a core service. All projects made progress during 2024, and HHS continues to work in this area.

Behavioral Health

As of June 30, 2024, the rate of Emergency Department (ED) visits for both suicide attempts and drug overdoses showed decreases compared to the FY 2023 baselines. The rate of ED visits for mental health conditions remained relatively stable during the performance period; however, the rate of ED visits for alcohol saw an upward trend. 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.

HHS Performance Results

In FY 2025, 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.

A subset of performance measures is included in the annual HHS Performance Plan and Report. In administration transition years, these reports are published separately as the HHS Performance Report and the HHS Performance Plan. On May 30, 2025, HHS published the FY 2026 Agency Performance Plan, which outlines the performance targets for 25 key performance measures in 4 generic strategic categories and 14 thematic areas.

HHS will report on the results of these measures in the FY 2027 Agency Performance Plan and Report (APPR), scheduled for publication in March 2026. Due to the necessary time for grantees and other data-reporting entities to deliver results, for the Divisions to verify the accuracy of those results, actual results for FY 2025 will not be available prior to the publication of the APPR.

FY 2026 Agency Performance Plan and FY 2024 Agency Performance Results

HHS published a significantly streamlined Agency Performance Plan that establishes a smaller, more impactful set of organizational performance goals, FY 2026 Agency Performance Plan.

Performance Goals, Objectives, and Results

As of December 2025, HHS reports meeting or exceeding targets in FY 2024 for 56 percent of the performance measures that have results available, with 28 percent of measures still pending (**Figure 1 and Figure 2**). Many of HHS's grant programs face delays in collecting, aggregating, and reporting on performance data, which contributes to the ongoing challenge of timely reporting on program performance.

HHS Performance Data Collection Timeline					
October 1, 2024 – September 30, 2025	October 1, 2025	December 2025	January 15, 2026	January 2026	February 2026
Period of performance for FY 2025 activities	Period of performance for FY 2025 closed Grantees have three months after the end of the FY to submit performance reports to the Agency	Grantee performance reports due	AFR published HHS reports on the most recently collected results for key performance goals using the APPR	Division program staff review and aggregate performance reports HHS collects performance data once a year, aligned to the primary performance reporting	HHS publishes the FY 2027 APPR and FY 2027 Congressional Justifications with FY 2025 results

Figure 1: FY 2024 Performance Status of Agency Performance Plan Measures

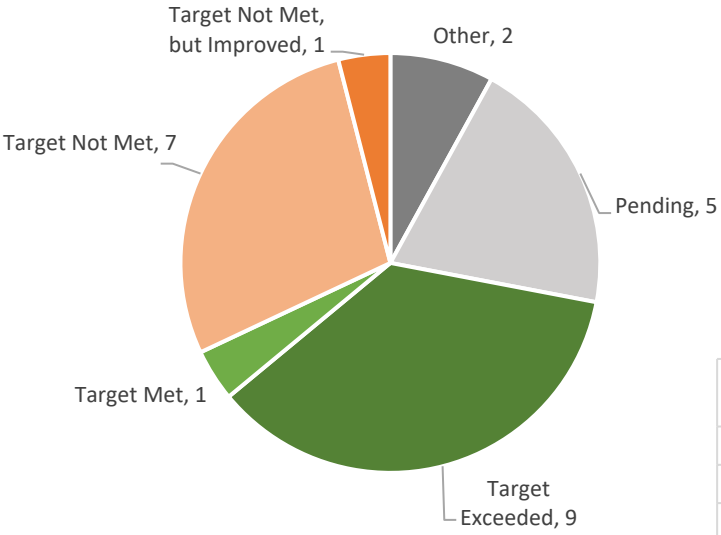
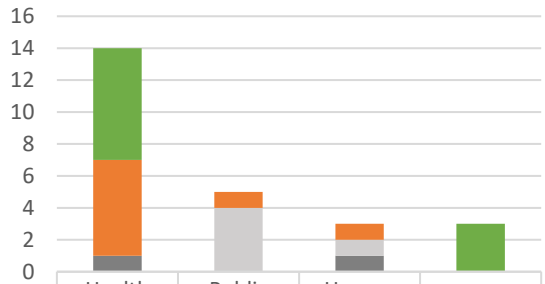


Figure 2: FY 2024 Performance Status of Agency Performance Plan Measures by Generic Goal Area



	Health Care	Public Health	Human Services	Research
Target Met or Exceeded	7			3
Target Not Met	6	1	1	
Pending		4	1	
Other	1		1	

Discussion of Performance Plan FY 2024 Results

Below is a summary of the performance measures and results featured in the FY 2024 Agency Performance Plan.

Health Care

The Make American Healthy Again agenda aims to investigate and address the causes of America's health burdens.

CMS, HRSA, SAMHSA, and IHS contribute performance measures to this goal area:

- **Primary Care (HRSA)**: Nearly 1,400 health centers operated 15,000 service delivery sites, serving 32.4 million patients in FY 2024. Growth has been supported by expanded clinic capacity and operating hours, though patient volume is projected to decline slightly in FY 2026.
- **Telehealth (HRSA)**: Telehealth Network Grant Program encounters are expected to decrease from a reported 35,392 in 2023 to a targeted 22,100 in FY 2024 as new cohorts established services, but usage is expected to rebound as providers begin their programmatic activities and services.
- **Prenatal Care (HRSA)**: Percent of patients receiving first-trimester care was maintained at 71 percent but missed the FY 2024 target of 72 percent. This underscores the need for early engagement to improve maternal and infant health.
- **Mental Health (SAMHSA)**: 7.9 million people were served by the public mental health system in FY 2024. This is short of the target of 8.2 million despite expanded access through the Community Mental Health Services Block Grant, which funds services for adults with serious mental illness and children with emotional disturbances.
- **Rural Health (HRSA)**: Rural Health Care Services Outreach, Network and Quality Improvement Grants (Outreach programs) continued to expand access and coordination of services in underserved communities; results are pending.
- **Long-term Care (CMS)**: Hospice survey compliance was 92.3 percent, short of the 98 percent goal. This is due to pandemic backlogs, though accrediting organizations have cleared much of their caseload. CMS is adjusting targets to 95.5 percent and expects improvement as states recover capacity.
- **CMS Program Management (CMS)**: In FY 2024, the Fraud Prevention System saved an estimated $207 million by screening Fee-For-Service (FFS) claims before payment, continuing a trend of year-over-year improvement in estimated savings. Priority initiatives for the Fraud Prevention System include expanding vulnerability detection capabilities, optimizing performance, upgrading system capabilities, and ensuring seamless integration of policy updates. Discussion of CMS's improper payments measures can be found in the "Other Information" section of the AFR.
- **Diabetes Care (IHS):** IHS met blood sugar and blood pressure control targets while expanding prevention lifestyle initiatives, and through programs such as the Special Diabetes Program for Indians. In FY 2024, the proportion of American Indians/Alaska Natives diagnosed with diabetes with poor glycemic control was 12.1 percent, below the 14.4 percent target. The proportion of American Indians/Alaska Natives with diagnosed diabetes who have controlled blood pressure was 55.8 percent, above the 52.4 percent goal.

Public Health

HHS is dedicated to safeguarding and improving public health. HHS protects individuals, families, and communities from infectious disease and prevents non-communicable disease through the development of effective treatments, therapeutics, and medical devices. Across the Department, programs work to ensure Americans have healthy foods, effective treatments for medical conditions, and proven strategies for long-lasting health.

FDA, CDC, and IHS contribute performance measures for this goal area:

- **Food Safety (FDA)**: New workflows for detecting Shiga toxin-producing E. coli in leafy greens are expected to increase accuracy and reduce outbreak risks. The new workflows will greatly increase the accuracy of confirmation and improve the ability to isolate pathogenic STECs when they are present.
- **Abbreviated New Drug Applications (FDA)**: FDA maintained its goal to review 90% of Abbreviated New Drug Applications within 10 months, ensuring that quality, affordable, safe and effective generic drug products are available to the American public.
- **Laboratory Capacity (CDC)**: PulseNet continued to strengthen outbreak detection by sequencing priority pathogens, enhancing food safety monitoring.
- **Infectious Disease (CDC)**: Through CDC's Antimicrobial Resistance Initiative and other investments to prevent health care-associated infections, strategies to reduce hospital-onset C. difficile infections focus on antibiotic stewardship, infection control, and disinfection practices.
- **Public Health Nursing (IHS)**: Public Health Nurses (PHN) are licensed, professional nursing staff that provide a range of direct care and public health services. The number of public health activities captured by the PHN data system was 263,303, which is below the 400,000 target. Efforts for FY 2025–2026 include leadership training, mentorship, and partnerships to improve workforce support and placement for recently graduated Bachelor of Science in Nursing students and newly hired PHNs.

Human Services

HHS's human services programs span the lifetime, from programs that protect children from violence to programs that ensure older Americans have the community supports they need to live independently.

ACF contributes performance measures for this goal area:

- **Family Safety (ACF)**: In 2024, the National Domestic Violence Hotline improved the call answer rate from 47 to 54 percent, but it remained below the 75 percent target. Given the expected continual rise in callers and online "chatters" contacting the Hotline, the Hotline is piloting a volunteer recruitment program, extending their existing queue management system for chats and texts to phone services when phone wait times exceed 15 minutes, increasing hours of training for new advocates, and increasing programmatic and financial support to StrongHearts Native Helpline.
- **Child Support (ACF)**: In FY 2024, 87 percent of cases had child support orders established, which is just below the 88 percent target. ACF supports states in establishing these orders through training, technical assistance, and the management of the Federal Parent Locator Service that helps find non-custodial parents to pay child support.
- **Human Trafficking (ACF)**: In FY 2024, the National Human Trafficking Hotline received 155,819 signals, of which 20 percent were substantive in nature; identified 12,130 potential human trafficking situations; and reported 2,642 cases to law enforcement.

Research

HHS is committed to using gold-standard research practices to expand scientific understanding of health care, public health, human services, and biomedical research to enhance the health and well-being of all Americans.

NIH and ASPR contribute performance measures for this goal area:

- **Research (NIH)**: Progress was made toward developing 10 antiviral drug candidates by FY 2026 and advancing prevention strategies for substance use disorders, including among youth and young adults.
- **Preparedness (ASPR)**: Biomedical Advanced Research and Development Authority (BARDA) expanded medical countermeasure development, supporting therapeutics, diagnostics, and vaccines critical to health security. BARDA increased the number of new licensed medical countermeasures by 11 in FY 2024.

Advancing Artificial Intelligence (AI) Infrastructure

HHS is committed on utilizing leading technologies to enhance efficiency, foster American innovation, and improve health outcomes. On December 4, 2025, HHS released its AI Strategy advancing to the next phase of the Department's transformative initiative to make AI available to the federal workforce, while integrating AI across internal operations, research, and public health. The HHS AI Strategy provides a framework to establish robust Department-wide infrastructure, accelerate AI innovation, and promote and ensure AI security throughout the health care and human services sector while respecting the American public's privacy (i.e., personally identifiable information) and complying with applicable law on privacy and security of such information.

Five Key Pillars to Facilitate the Implementation of HHS's AI Vision

1. Ensure Governance and Risk Management for Public Trust
2. Design Infrastructure and Platforms for User Needs
3. Promote Workforce Development and Burden Reduction for Efficiency
4. Foster Health Research and Reproducibility through Gold-Standard Science
5. Enable Care and Public Health Delivery Modernization for Better Outcomes

The HHS AI Strategy embraces a "OneHHS" approach that invites Division collaboration in the development of a holistic and robust Department-wide AI infrastructure that streamlines workflows and enhances cybersecurity. We continue striving to prioritize responsible governance, risk-based oversight, and a secure infrastructure that fosters an environment where AI can be safely scaled to enhance program delivery, optimize resource operations, and improve service outcomes for the public it serves. To learn more about HHS's AI enterprise-wide AI platforms and initiatives, visit our HHS AI page.

Accountability, Transparency, and Reliability

USAspending.gov reports HHS total obligations, including Contracts, Grants, and Other Financial Assistance awards, which are categorized by object class based on the types of goods or services provided. As shown below, HHS spends the largest portion of its budget on Grants and Other Financial Assistance, making it the federal government's top grant-making agency. HHS performs a monthly reconciliation of award-level data with financial system records to ensure the completeness and accuracy of data on USAspending.gov.

GRANTS & OTHER FINANCIAL ASSISTANCE

$2.0 TRILLION

CONTRACTS

$26.7 BILLION

DATA QUALITY

The FY 2025 Data Quality Assessment was performed in accordance with the OMB Memorandum M-22-12, *Advancing Effective Stewardship of Taxpayer Resources and Outcomes in the Implementation of the Infrastructure Investment and Jobs Act*, demonstrating HHS's accountability and compliance in evaluating the quality of financial assistance data elements.

TERMINATIONS

In accordance with the Presidential Memorandum on Radical Transparency, HHS publicly reports Grants and Contract Awards terminated after January 20, 2025. HHS publishes Grant terminations on the Tracking Accountability in Government Grants System, and contract terminations on HHS's Radical Transparency page. The data reported below is as of October 3, 2025.

TERMINATED MORE THAN

1,600

GRANT AWARDS

TERMINATED MORE THAN

5,700

CONTRACT AWARDS

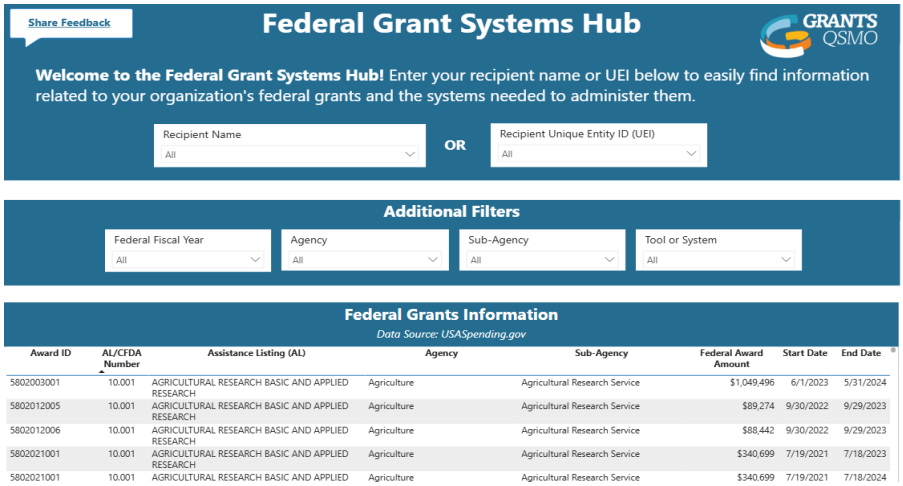
Grants Quality Service Management Office

Authorized by OMB Memorandum M-19-16, *Centralized Mission Support Capabilities for the Federal Government*, and through OMB's designation of HHS as the Grants Quality Service Management Office (QSMO), the Grants QSMO is responsible for establishing a marketplace of high-quality shared solutions and services, to ensure long-term sustainability, and drive the implementation of grants data standards. The Grants QSMO's vision is detailed in **Figure 3**. OMB continues to support the Grants QSMO, as reflected in its inclusion in 2 CFR §1.305.

Figure 3: Grants QSMO Vision

In FY 2025, the Grants QSMO continued to lead transformative initiatives in federal grants management, working in close coordination with the Council on Federal Financial Assistance (COFFA). These collaborative efforts ensured that modernization, data standards, and marketplace maturity remained central to government-wide strategy and policy framework for effective grants mission delivery.

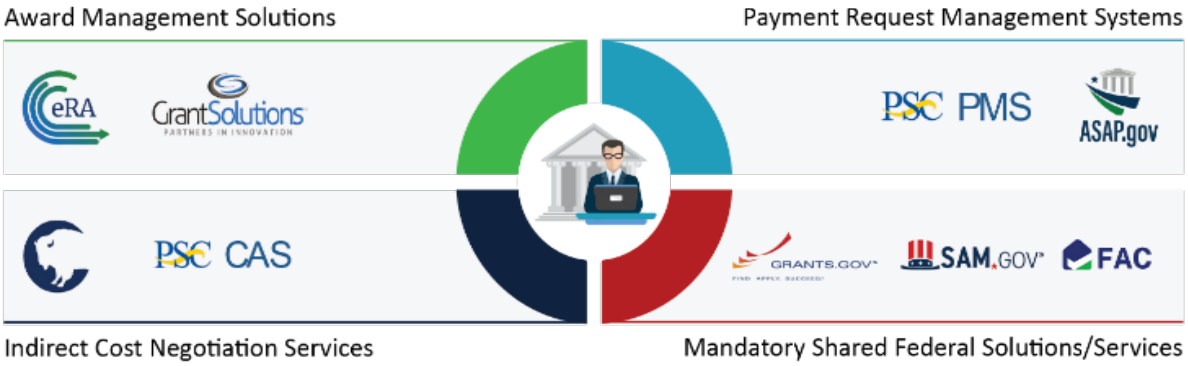
Figure 4: Federal Grant Systems Hub



Building on insights from the Grants IT Demand Survey, the Grants QSMO updated and officially launched the Federal Grant Systems Hub, a public-facing, recipient-focused resource accessible via Grants.gov, that was recognized with an American Council for Technology and Industry Advisory Council (ACT-IAC) 2025 Innovation Award. The Hub, pictured in **Figure 4**, integrates grant award data from USAspending.gov with recipient-facing grant system information, delivering tailored results to individual recipient organizations. Featuring 365 hyperlinks to 117 systems, it is designed to enhance the federal grant recipient experience by offering transparent access to grants management data and systems, ultimately reducing administrative burden.

A core objective of the Grants QSMO is to provide a robust marketplace of grants management solutions and services through the Grants QSMO Marketplace (Marketplace). This Marketplace equips agencies with essential information to support informed decision-making around the adoption of shared solutions and services across the full grants lifecycle. Since its inception, the Grants QSMO has consistently seen strong demand for both federal shared service providers and commercial offerings (see **Figure 5***)*, enabling agencies to access high-quality grants management systems and solutions.

Figure 5: Grants QSMO Marketplace Providers



Plus **6 commercial award management vendors** on the Grants QSMO Catalog of Market Research.

A key component was completing the tri-annual Grants IT Demand Survey which received 38 responses, including a 100 percent response rate from 22 CFO Act COFFA member agencies plus 16 non-CFO Act federal awarding agencies. The survey expanded the QSMO's data on grants management systems by capturing details such as unique investment identifiers, system usage across the Federal Integrated Business Framework, and details on system integrators. The assessment revealed a widespread agency drive to consolidate the grants IT environment, while also surfacing additional agency needs. This feedback has guided the QSMO's efforts to address the strong demand for federal and commercial solutions.

The Grants QSMO prioritized agency engagement by implementing a targeted outreach strategy focused on data-driven modernization objectives for CFO Act agencies operating aging and custom-built systems. To support informed investment decisions, the Grants QSMO developed the Agency Profile Dashboard, a user-friendly tool that provides a comprehensive overview of each agency's grants systems environment, delivering value to individual agencies and advancing broader federal modernization efforts.

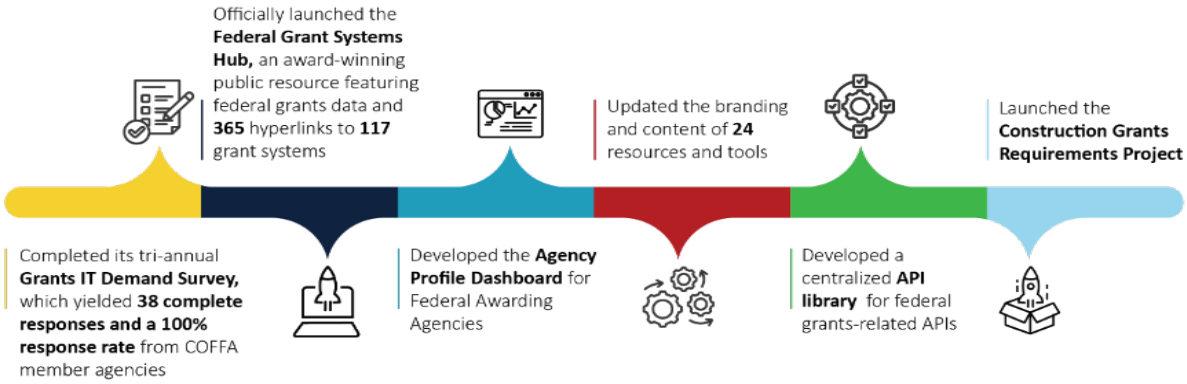
The Grants QSMO also advanced its use of AI through several key initiatives, including the development of an Application Programming Interface (API) Library—a centralized repository for U.S. federal grants-related APIs. This resource enables developers to quickly access integration references, facilitating seamless data exchange across federal systems, improving system functionality, reducing errors, and accelerating operations.

To further leverage data and AI capabilities, the Grants QSMO launched the Construction Grants Requirements Project in response to challenges reported by agencies in managing grants for physical assets and infrastructure. These grants often require specialized system features not currently supported by existing providers, driven by policies such as the Build America, Buy America Act, National Environmental Protection Act, Council on Environmental Quality Permitting Technology Plan, and 2 CFR Property Management guidelines.

Performance Goals, Objectives, and Results

Figure 6 summarizes the Grants QSMO's key FY 2025 achievements, highlighting progress across modernization, data and AI integration, marketplace development, and strengthened agency engagement efforts.

Figure 6: Grants QSMO FY 2025 Achievements



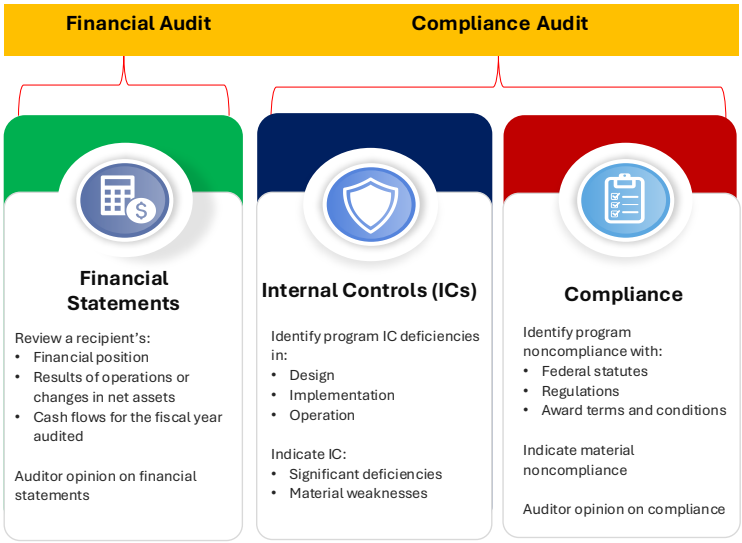
Looking ahead to FY 2026, the Grants QSMO will continue to mature the Marketplace to ensure it aligns with the evolving priorities and operational realities of its federal partners. Key priorities include supporting agencies through one-on-one engagement and IT modernization investment reviews, advancing special initiatives such as the Construction Grants Requirements Project and hosting customer workshops to guide successful migration to shared systems, and expanding the use of AI to enhance data-driven insights. These efforts aim to strengthen support for grants stakeholders and deliver greater value across the federal grants ecosystem.

Single Audit

HHS is the largest grant-making agency in the United States, awarding approximately $2 trillion in federal financial assistance annually on programs carried out by states, territories, tribes, and educational and community organizations. Recipients of federal award funding that spend $1 million or more during their fiscal year must undergo a Single Audit, as required by Title 2 of the Code of Federal Regulations Part 200 (Uniform Guidance) and the *Single Audit Act of 1984*, as amended; prior to FY 2025, the minimum was $750,000.

The Single Audit is one of the Department's most important oversight tools, providing broad coverage of Federal awards and an objective assessment of how recipients manage their funds. As shown in **Figure 7**, a Single Audit includes both a financial audit and a compliance audit. Recipients must submit their audit reports to the Federal Audit Clearinghouse (FAC), where the reports are accessible to awarding agencies and the public; unless otherwise indicated, the following figures and charts are sourced from the FAC.

Figure 7: Single Audit Overview



In FY 2025, recipients of HHS funding submitted 44 percent of the 47,668 Single Audit reports nationwide, covering nearly half (47 percent) of the more than $2.163 billion in audited federal spending (see **Figures 8 and 9**).

Figure 8: Single Audit Reports Received During FY 2025

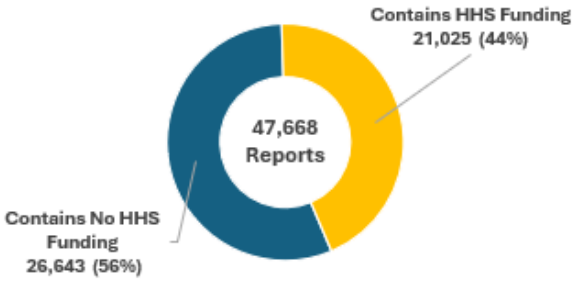
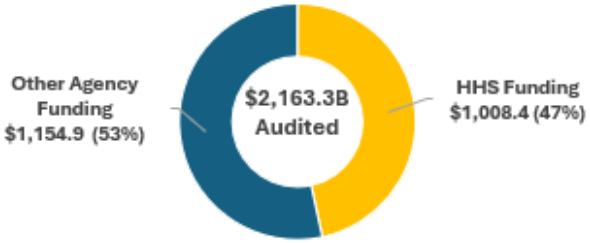


Figure 9: Funding Audited in Single Audit Reports Received During FY 2025
(In billions)



In FY 2025, about 72 percent of all HHS programs subject to audit received compliance testing, which is based on program expenditures, risk level, and other factors. These can range from large state-administered federal programs, such as Medicaid and Temporary Assistance for Needy Families, to locally managed federal programs like community health centers and Biomedical Research. In FY 2025, HHS recipients submitted 21,025 Single Audit reports. Nearly all of which (91 percent) came from local governments and non-profits. Most of the dollars audited were tied to state programs, accounting for 81 percent of the $1,008.4 billion in HHS audited expenditures (see **Figures 10 and 11**).

Figure 10: HHS Single Audit Report Received During FY 2025 by Entity Type

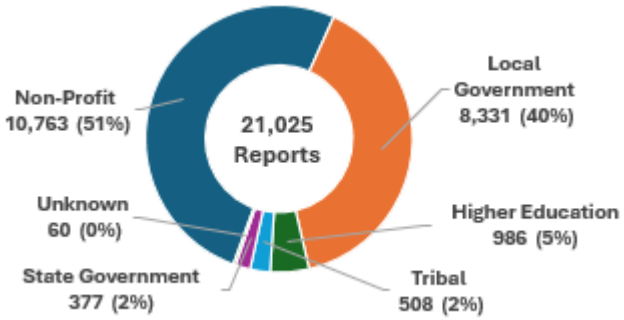
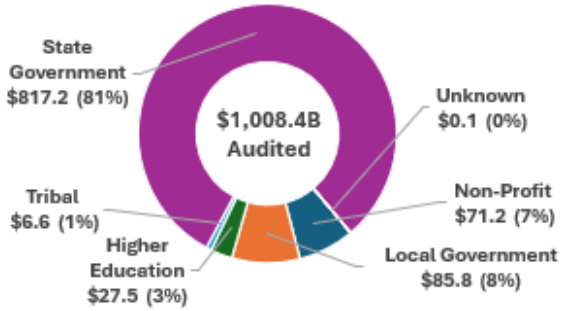


Figure 11: HHS Single Audit Report Received During FY 2025 by Entity Type
(In billions)



Audit findings alert both recipients and awarding agencies to internal control or compliance problems that might otherwise go undetected. These findings can involve questioned costs, ineligible clients receiving services, mistakes in required financial or performance reports, or other issues.

To ensure problems are fixed promptly, the Uniform Guidance requires recipients to prepare a corrective action plan for each sustained finding, and awarding agencies must review and approve the plans within six months of the FAC accepting the Single Audit report. In FY 2025, auditors flagged nearly $200 million in questioned costs, and HHS confirmed about 70 percent as overpayments (see the Payment Integrity section for recovery details).

The Single Audit provides comprehensive coverage of federal awards and independent assessments of how recipients manage public funds. As a cornerstone of HHS's internal control framework under OMB Circular A-123 and the *Federal Managers' Financial Integrity Act of 1982*, Single Audits strengthen accountability, support program integrity, and reinforce the Department's stewardship of taxpayer dollars.

Systems, Legal Compliance, and Internal Control

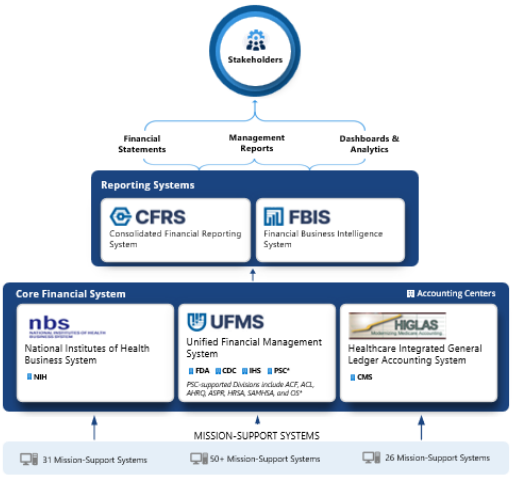
Systems

Financial Management Systems Overview

The HHS Financial Management Systems Environment (FMSE) provides the foundation to manage approximately **$3.1 trillion in budgetary resources** entrusted to the Department in FY 2025. The FMSE consists of two Department-wide reporting systems and a core financial system, as shown in **Figure 12**. The reporting systems, Consolidated Financial Reporting System (CFRS) and Financial Business Intelligence System (FBIS), support financial statement compilation, data-driven business decisions, and managerial reporting.

HHS FINANCIAL MANAGEMENT SYSTEMS ENVIRONMENT PRIMARY OBJECTIVES	
i)	Efficiently **process financial transactions**
ii)	Provide **complete and accurate** financial information
iii)	Strengthen **internal controls and mitigate risk**
iv)	Improve **data integrity**
v)	Provision **federal contracts, grants, and financial**

Figure 12: Financial Management Systems Environment



The core financial system's three instances—National Institutes of Health Business System Cloud (NBSC), Unified Financial Management System (UFMS), and Healthcare Integrated General Ledger Accounting System (HIGLAS)—integrate with 100+ mission-support systems, including external Government-wide systems, HHS enterprise systems, and HHS Division systems. All three instances operate on the same commercial off-the-shelf platform, promoting Department-wide data standardization. The HHS financial management systems, detailed in **Figure 12** fulfill HHS's financial accounting and reporting needs, delivering efficient and timely disbursement of funds critical to providing effective health and human services to all Americans. More details on each system's functions, data management, and agency support can be found in the historic Agency Financial Report.

The HHS FMSE complies with all applicable federal laws and regulations. Further details on relevant legislation can be found in the HHS Financial Policy Library.

Financial Management Systems Improvement Strategy

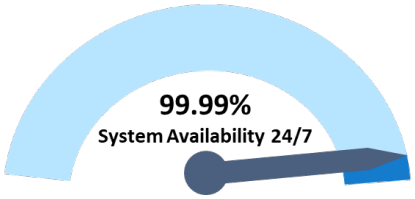
HHS is navigating a rapidly evolving environment with new federal mandates, rising security threats, and the need for greater accountability, all while optimizing system investments. To stay ahead, HHS's financial management systems improvement strategy (see **Figure 13**) brings together five collaborative programs that rapidly integrate and address new federal mandates, drive innovation, strengthen security, and boost efficiency. These programs leverage advanced technology, enhance financial oversight, improve analytics, automate processes, and engage stakeholders to deliver efficiencies. By **prioritizing modernization** and **user needs**, HHS improves transparency, accelerates service delivery, reduces administrative burden, supports compliance, and provides more accurate and timely information to partners and the

Figure 13: Financial Management Systems Improvement Strategy

public—ensuring each initiative strengthens financial management and delivers lasting value across the organization and beyond.

Financial Management Systems Improvement Strategy

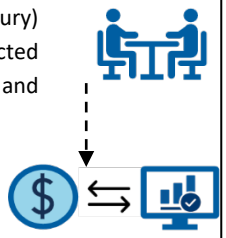
The Financial Systems Improvement Program (FSIP) is a multi-year program that enables HHS to take advantage of state-of-the-art technology, strengthen financial stewardship, and increase the return on system investment. HHS is actively pursuing multiple initiatives to generate efficiencies and improve the effectiveness of the FMSE.



Financial Business Intelligence Program

Advanced Government Invoicing (G-Invoicing) Solution

- Matured the **G-Invoicing solution** to comply with the Department of the Treasury's (Treasury) mandate for Intra-governmental Payment and Collection (IPAC) buy/sell activity and conducted detailed data analysis, reviewed more than 20 complex processes, mapped business workflows, and developed a comprehensive transition plan for buy/sell activity.
- Established HHS as a leader in G-Invoicing implementation, consistently ranking among the **top three agencies for overall G-Invoicing adoption**, with **86 percent** of HHS's intragovernmental transactions processed through G-Invoicing.



Launched Grants System Integration

- Completed the **Grants Closeout Business Process Reengineering (BPR)** root cause analysis to identify issues causing system discrepancies between the financial and grants systems and inform a future solution that will **consolidate services, synchronize data, increase data visibility, and provide real-time information sharing** across systems.

Submitted Executive Orders (EO) Compliance Plan

- Delivered the **EO Compliance Plan** highlighting HHS's significant progress in alignment with EO 14247 and 14249, which mandate the phasing out of paper payments, the consolidation of HHS's financial systems, and strengthening safeguards to reduce improper payments.
- Designed the plan to equip federal agencies with tools to fully implement and adhere to the requirements set forth in the EOs ensuring **legal and regulatory compliance**; **standardized implementation**; tracked progress and **accountability**; identified risks and barriers; **transparency** and **public confidence**.

Initiated Go.gov

- Established the Go.gov modernization initiative to **deliver a single, centralized travel and expense management solution** used by over 124 civilian agencies that **streamlines** and **automates** the full **lifecycle of federal travel**, including travel authorizations, reservations, expense reimbursements, and compliance reporting.
- Actively coordinating across the department with financial and travel communities to **solidify business processes**, and **reengineer system capabilities** to align with compliance requirements set forth by the 2027 General Services Administration mandate.

Enhanced Network Security with FastConnect

- Implemented FastConnect architecture to provide a **dedicated and encrypted point-to-point connection** between HHS's primary, onsite network and secondary Oracle Cloud Infrastructure (OCI), significantly **mitigating the risk of denial-of-service incidents** and marking a substantial **improvement in our performance, reliability,** and **operational resilience.**

Systems, Legal Compliance, and Internal Control

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 2025 through dedicated efforts to bolster FBIS's capabilities and adoption.

Improved FBIS Analytics Platform with Oracle Cloud Analytics (OAC)

- Migrated FBIS to a **cloud-based analytics platform**, Oracle Analytics Cloud (OAC), for business intelligence, modernizing the reporting platform to include built-in capabilities that address the entire **data and analytics process** with **integrated artificial intelligence (AI)** and **machine learning**. Users now have access to enhanced **predictive analytics and actionable insights**, enabling faster, more cost-effective, and data-driven decision-making across the organization.

Introduced FBIS Assistant

- Launched the FBIS Assistant, a **virtual AI chatbot**, revolutionizing the user experience by facilitating quick access to system resources, leading to decreased information search time and productivity optimization**.**

Advanced Government Spending Data Model (GSDM)

- Conducted the **Government Spending Data Model (GSDM) evaluation** and enhanced the spending model to address upcoming data collection changes mandated by Treasury to standardize federal spending data and ensure transparency and consistency in reporting.
- Looking Forward; HHS will continue to innovate federal spending data collection and reporting through implementation of new data elements in compliance with federal laws and regulations (GSDM Treasury Mandate).

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.

Enhanced Financial Management Processes with Robotic Process Automation (RPA)

- Matured financial management processes through RPA including implementation of three new automations and maintenance of 18 active automations for standard procedures, resulting in **over 13,000 manual hours saved** in FY 2025.

Systems, Legal Compliance, and Internal Control

Financial Systems Security and Internal Controls Program

Ensuring the reliability, availability, and security of HHS's financial systems is critical. The Financial Systems Security and Internal Controls Program established a foundation for effective governance and oversight, guiding coordinated actions to address issues and mitigate risks. These initiatives and activities support the achievement of strategic goals and outcomes.

Matured Financial Systems Control Environment

- Sustained HHS financial systems with **no Information Technology (IT) material weakness since FY 2018** and remained substantially compliant with *Federal Financial Management Integrity Act of 1996* (FFMIA) requirements.
- Improved security posture and reduced risk of HHS's financial systems control environment. As of September 30, 2025, **80 percent of FY 2024 audit findings and 100 percent of FY 2024 high risk findings were remediated.** In addition, **all IT general controls tested** by the external auditors for FY 2025 **were effective**.

- Conducted the FY 2025 Management Assessment Framework (MAF) assessment and determined that **93 percent of the controls tested were effective for FY 2025, with no material weaknesses**, proactively mitigating risks and striving toward a more mature and resilient control environment.
- Demonstrated remediation progress and effectiveness by **decreasing overall audit findings by 94 percent since FY 2013**, and receiving **no** Federal Information System Controls Audit Manual (FISCAM) **audit findings for UFMS and CFRS for the third consecutive year** in a row.
- Continued to lead department-wide financial systems A123 internal controls assessments by offering the **FY 2025 HHS A-123 IT Assessment Guidance Workshop** for six Accounting Centers and conducting management assessment to support the FY 2025 HHS Statement of Assurance.

Financial Management Governance and Enterprise Program Management

HHS implemented Financial Management Governance and Enterprise Program Management to identify key frameworks to boost stakeholder engagement in decision-making and align enterprise-wide priorities.

Increased Department-wide Collaboration

- Collaborated with Divisions through the **Federal Management Governance Board (FGB)**, addressing financial management policies, data, systems, and technology across the Department, as well as department-wide initiatives including Financial Management, Grants, Cybersecurity, and the Human Resources Quality Service Management Offices standards; Electronic Invoicing and G-Invoicing implementations, General Services Administration's (GSA's) Go.gov initiative, and Single Audit initiatives in FY 2025. 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**.

- Provided a sustaining framework for the HHS financial management community stakeholders through the **Enterprise Program Management Office (EPMO)**, **strengthening coordination, collaboration, and shared responsibilities** related to programs and projects across the Department.

Legal Compliance

Antideficiency Act

The *Antideficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, obligating before funds are available, and 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.

Chief Financial Officers Act of 1990, Government Management Reform Act of 1994, Government Performance and Results Act of 1993, and GPRA Modernization Act of 2010

The *Chief Financial Officers Act of 1990* (CFO Act) required select executive branch federal agencies to submit annual financial statements and undergo independent financial audits. To ensure timely and accurate reporting of financial statements, the CFO Act established Chief Financial Officer positions in 24 major federal agencies (i.e., 24 CFO Act agencies) who were also responsible for financial management oversight, effective internal control implementation, and financial system modernization. The CFO Act strengthened federal financial oversight by improving the quality and reliability of financial data, enhanced accountability for the use of taxpayer funds, supported effective decision-making through accurate reporting, and paved the way for government-wide audit reporting.

The *Government Management Reform Act of 1994* (GMRA) required the preparation and submission of audited financial statements to Congress and the public in 24 CFO Act agencies. GMRA also mandated preparation and submission of government-wide consolidated audited financial statements to report on the government's financial performance and position. HHS strives for strong fiscal stewardship and transparency by complying with the CFO Act and GMRA requirements.

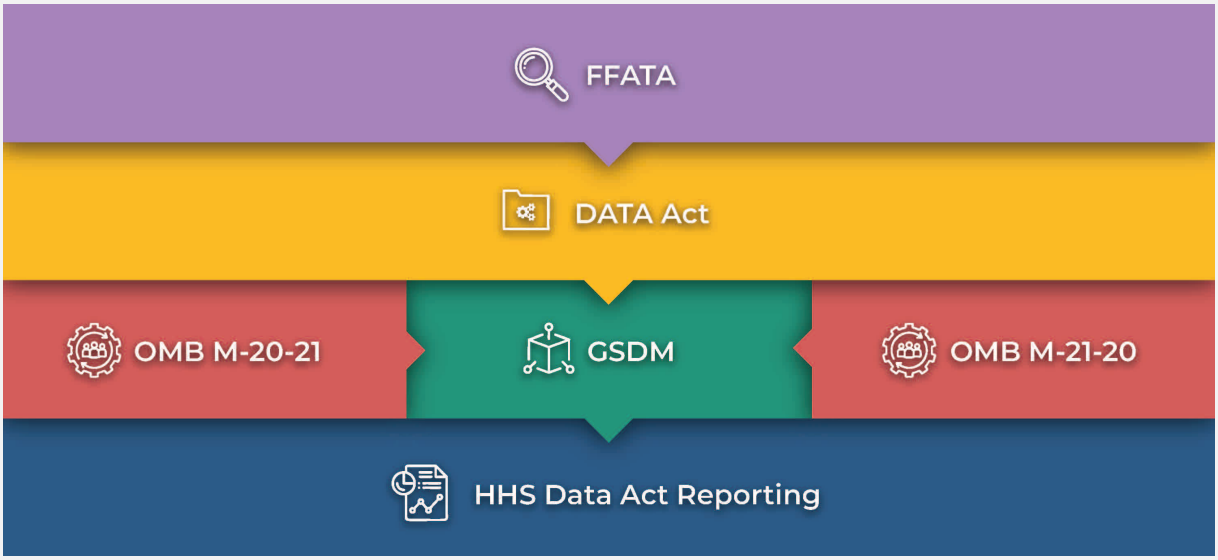
The *Government Performance and Results Act of 1993* established requirements for federal agencies to create strategic plans, set measurable goals, and report on performance. The *GPRA Modernization Act of 2010* strengthened these requirements by mandating priority goals, frequent performance reporting, and greater transparency. These enhancements, detailed in the Performance section of the MD&A, demonstrate HHS's commitment to achieving its mission and goals.

Digital Accountability and Transparency Act of 2014

The *Digital Accountability and Transparency Act of 2014* (DATA Act) was enacted to improve transparency in federal spending by requiring agencies to report all expenditures, beyond just grants and contracts, using standardized formats. It builds on the *Federal Funding Accountability and Transparency Act of 2006* (FFATA), which first mandated public reporting of financial assistance but lacked consistency and scope. The DATA Act ensures that spending data is published on USAspending.gov, making it accessible to the public, lawmakers, and oversight bodies.

The U.S. Department of the Treasury developed the Governmentwide Spending Data Model (GSDM) as the authoritative framework for defining, formatting, and structuring hundreds of data elements that describe how federal money is spent to support consistent and high quality reporting. Further refinements to reporting requirements were driven by OMB Memorandums M-20-21, *Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)*, and M-21-20, *Promoting Public Trust in the Federal Government through Effective Implementation of the American Rescue Plan Act and Stewardship of the Taxpayer Resources*, which increased the reporting frequency and reinforced the importance of data quality, cross-file validation, and certification processes to ensure accurate public reporting.

Beginning in FY 2026, the GSDM will require agencies to include the new Program Activity Reporting Key (PARK) in their DATA Act submissions. This unique identifier, assigned by OMB, will allow program activity tracking at the Treasury Account Symbol (TAS) level, streamlining how agencies align the President's Budget with spending.



Together the DATA Act, GSDM, and OMB guidance have strengthened HHS's ability to deliver transparent, reliable, and timely financial data; support public trust in how taxpayer money is used; and enable oversight by increasing accountability, reducing waste, and improving data quality.

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 weaknesses 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 to improve accountability in federal programs. The Department works with its Divisions 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 Divisions to remediate major weaknesses and non-compliance issues by identifying the root causes and ensuring active oversight of corrective actions. Based on internal reviews and the FY 2024 audit, HHS is confident that its internal controls are operating effectively and its financial systems comply with requirements. For more details, see the "Internal Control" and "Management Assurance" sections below.

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 implement corrective actions. HHS actively works to prevent, detect, and reduce improper payments by reviewing its programs and activities using risk models, statistical estimates, and internal control reviews.

HHS conducted 97 improper payment risk assessments in FY 2025, reflecting a 10 percent increase from FY 2024. No new risk-susceptible programs were identified. HHS maintains a longstanding estimation and reporting process, strengthened by corrective actions across its risk-susceptible programs. HHS reported improper payment estimates and accompanying information for 9 of the 10 risk-susceptible programs in the FY 2025 AFR.

HHS utilizes the Do Not Pay portal to verify both payments and recipients, helping identify potential improper payments or ineligible recipients. In FY 2025, 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.

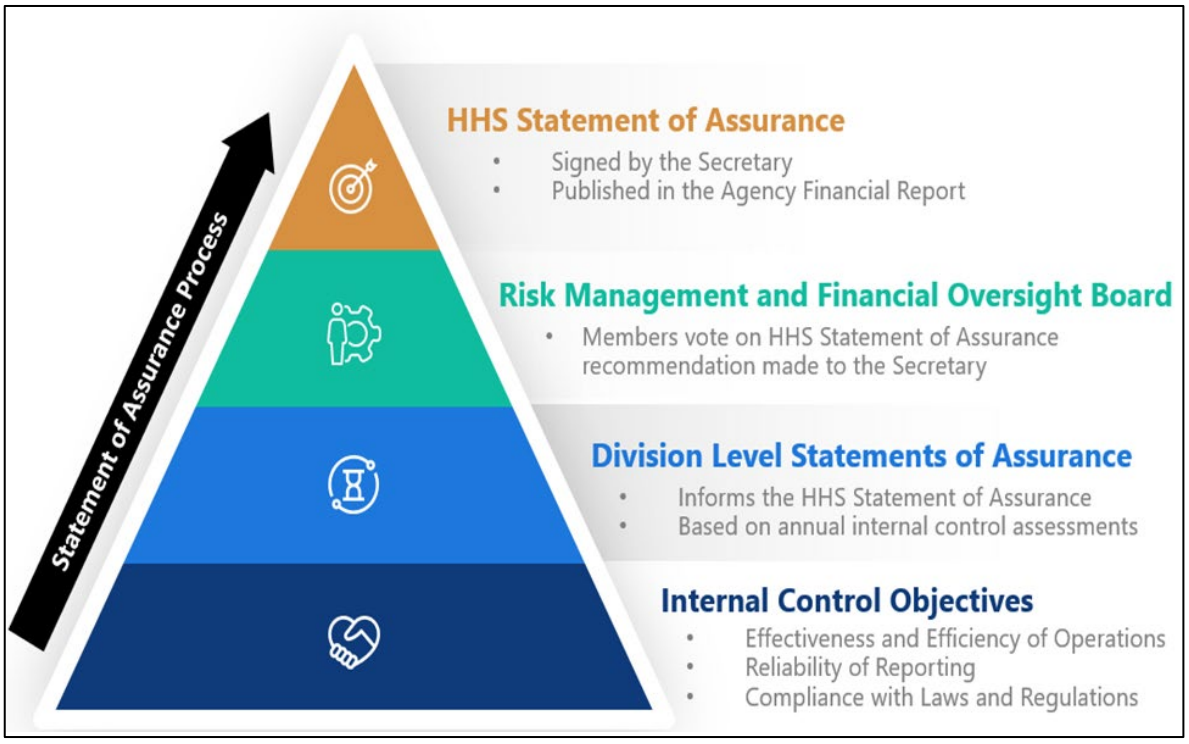
Internal Control

FMFIA requires agency heads to annually assess and report on internal control and financial systems that safeguard federal programs. This ensures efficient operations, reliable reporting, compliance with laws and regulations, and proper stewardship of federal assets. 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.

OMB Circular A-123 guides agencies in strengthening accountability and program effectiveness by managing risks and routinely assessing internal controls. HHS continues to enhance its internal control process to better identify risks, develop effective responses, and implement timely corrective actions. Ongoing communication with Divisions supports the assessment of internal controls, including disaster-related controls, and helps improve processes to ensure they meet management's objectives.

HHS management is responsible for maintaining effective internal controls. As part of this responsibility, leadership regularly assesses control effectiveness and provides annual assurance statements. The HHS Risk Management and Financial Oversight Board reviews these statements from the Divisions and recommends Department-wide assurance for the Secretary's annual Statement of Assurance, as illustrated in **Figure 14**.

Figure 14: Secretary's Annual Statement of Assurance Process



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, 2025, 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 promote accountability and transparency in managing taxpayer dollars and strengthen its internal control and financial management systems.

/Robert F. Kennedy, Jr./

Robert F. Kennedy, Jr.
Secretary
January 14, 2026

Systems, Legal Compliance, and Internal Control

Summary

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

HHS identified material noncompliance with PIIA because the Department did not report (a) a required improper payment estimate and (b) an improper payment estimate below the statutory 10 percent threshold.

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.

Temporary Assistance for Needy Families (TANF)

HHS identified material noncompliance with PIIA because the Department did not report an improper payment estimate for TANF. Statutory limitations under 42 U.S.C. §617 preclude the Department from requiring states to participate in a TANF improper payment measurement. These limitations, which have been reported in prior years, remain in place and continue to limit the availability of state-level data. Despite these constraints, HHS remains committed to ensuring TANF funds are used as authorized by Congress and to strengthening fiscal and program integrity through ongoing data reporting and technical assistance to states.

Head Start

The Head Start program did not report an improper payment estimate below the PIIA statutory 10 percent threshold. To reduce improper payments, enhance accountability, and ensure compliance with statutory requirements, HHS has begun implementing corrective actions focused on strengthening oversight and improving recipient compliance. HHS is also identifying ways to integrate improper payment reviews into existing monitoring activities.

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Financial Summary and Highlights

For the 27th consecutive year, HHS received an unmodified or "clean" audit opinion on the Consolidated Balance Sheet, Statement 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, 2025. 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 relationship 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".

As a federal entity, HHS's financial position and activities are significant to the government-wide statements. Based on the *FY 2024 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 Division, CMS. CMS alone consistently stewards the largest share of HHS's resources.

Balance Sheet

To communicate performance for HHS at fiscal year (FY)-end, the Consolidated Balance Sheet shows 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 2025 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)

		2025
Fund Balance with Treasury	$	659.4
Investments, Net		414.3
Accounts Receivable, Net		50.0
Other Assets		31.0
Total Assets	**$**	**1,154.7**
Entitlement Benefits Due and Payable	$	164.0
Pensions and Post-Employment Benefits		22.6
Accrued Liabilities		18.0
Contingencies & Commitments		17.8
Other Liabilities		12.6
Total Liabilities	**$**	**235.0**
Net Position	**$**	**919.7**
Total Liabilities and Net Position	**$**	**1,154.7**

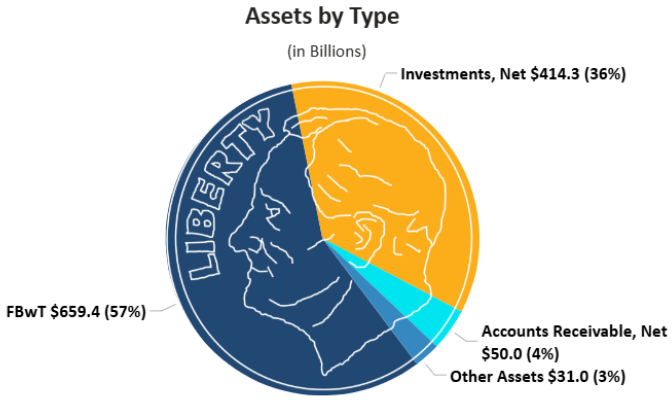
[1]HHS's net cost is 23 percent of the federal government's total costs, Social Security Administration's net cost is 21 percent, Department of War's net cost is 17 percent, and Interest on Treasury Securities held by the public's net cost is 12 percent. All remaining agencies combined only represent 27 percent. Source: *FY 2024 Financial Report of the U.S. Government*.

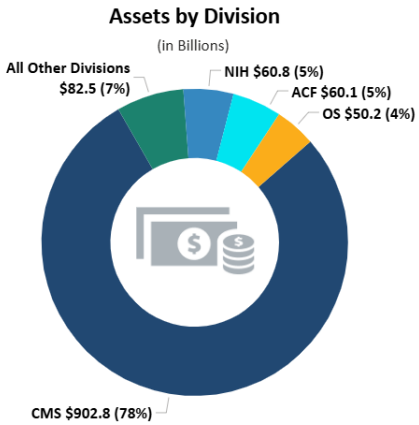
Financial Summary and Highlights

Assets

The total assets for HHS were $1,154.7 billion as of September 30, 2025, representing the value of what HHS owns and manages. Fund Balance with Treasury (FBwT) and Investments comprise $1,073.7 billion or 93 percent of HHS's total assets.

The HHS "Assets by Division" chart [2] shows asset distribution within HHS, excluding eliminations. The Divisions asset balances ranged from $366 million for AHRQ (shown in All Other Divisions) to $902.8 billion for CMS.

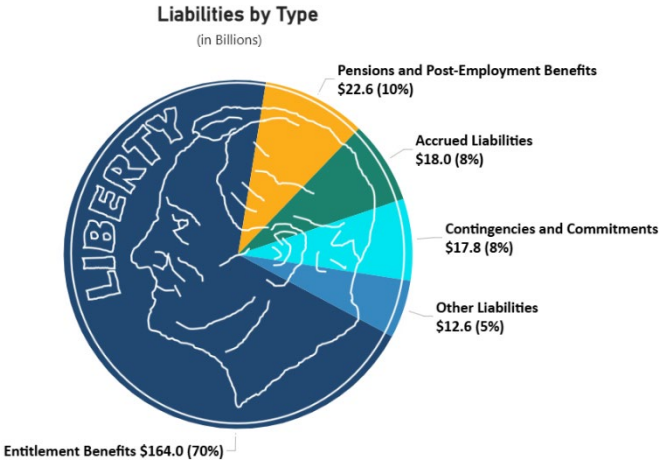


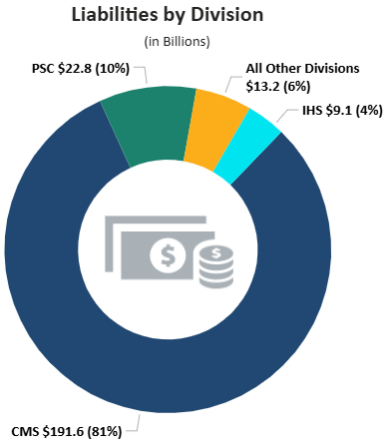


Liabilities

The total liabilities for HHS were $235.0 billion as of September 30, 2025, representing the amounts HHS owes from past transactions or events.

The HHS "Liabilities by Division" chart shows liability distribution within HHS, excluding eliminations. The Divisions with the largest and smallest asset balances are also the Divisions with the largest and smallest liabilities. With the majority share, CMS reports $191.6 billion or 81 percent of the HHS liabilities, while AHRQ (shown in All Other Divisions) has liabilities of $15 million.



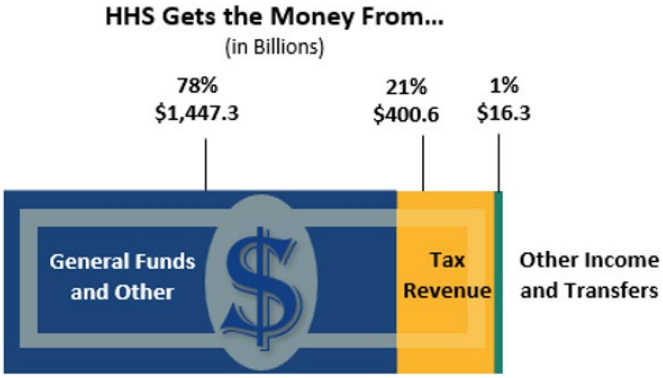


[2]The charts on this page may not sum to 100% due to rounding.

Statement of Changes in Net Position

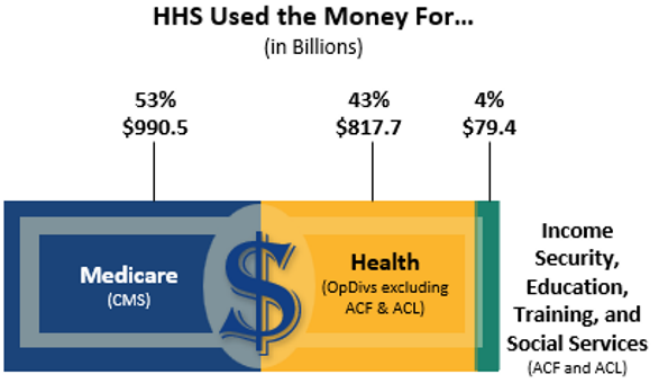
The Statement of Changes in Net Position displays the activities affecting the difference between the beginning net position and ending net position, as shown on the HHS Consolidated Balance Sheet. This is also represented as the difference between assets and liabilities. Changes in assets are shown 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. As presented in the "HHS Gets the Money From" chart, HHS's largest financing source is General Funds and Other.



Statement of Net Cost

The Consolidated Statement 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, 2025, totaled approximately $1,887.2 billion. The "HHS Used the Money For" chart shows consolidating costs by major budget function [3], 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 2025, total net costs for Medicare of $990.5 billion and Health of $817.7 billion account for 96 percent of HHS's annual net costs.



[3]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

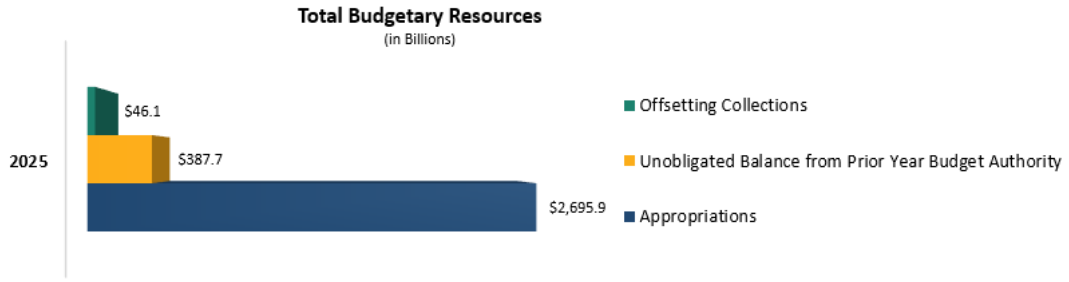
The table below presents FY 2025 Consolidated Net Cost of Operations, which breaks costs into Responsibility Segments between CMS and the remaining Divisions in Other Segments.

Net Cost of Operations
(in Billions)

	2025
Responsibility Segments:	
CMS Gross Cost	$ 1,867.9
CMS Earned Revenue	(176.9)
CMS Net Cost of Operations	$ 1,691.0
Other Segments:	
Other Segments Gross Cost	$ 204.4
Other Segments Earned Revenue	(8.2)
Other Segments Net Cost of Operations	$ 196.2
Net Cost of Operations	**$ 1,887.2**

Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout FY 2025, and the status of those resources. The primary components of HHS's resources, totaling approximately $3.1 trillion for FY 2025, are appropriations from Congress, resources not yet used from previous years (unobligated balances from prior year budget authority), and spending authority from offsetting collections.



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 Sheet, Consolidated Statement of Net Cost, Consolidated Statement of Changes in Net Position, or Combined Statement of Budgetary Resources.

Financial Summary and Highlights

Actuarial present values are computed under the intermediate set of assumptions specified in the *2025 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 *Social Security Act's* current-law provisions [4] as of the date of the release of the Medicare Trustees Report.

The first exception is that the Part A projections disregard payment reductions that would occur if the Medicare HI trust fund became depleted. 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 Medicare 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 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, legislation has delayed implementation three times, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The COVID-19 pandemic is no longer projected to have a significant impact on the Medicare program. Fee-for-service per capita spending has stabilized and the Trustees rely more on recent experience when developing the cost projections. The only remaining adjustment is to account for the surviving population's morbidity improvement, which is expected to continue to affect spending levels through 2029.

The SOSI presents the following actuarial estimates:

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

[4]Because it was enacted after the release of the 2025 Medicare Trustees Report, the projections do not reflect the impact of the Medicare provisions in the *One Big Beautiful Bill Act of 2025* (OBBBA: Public Law 119-21). Three provisions affect the Medicare program directly, with a negligible estimated impact on spending. The combined net effect of the income tax provisions in the OBBBA results in less overall tax liability for Social Security beneficiaries, meaning the HI trust fund is projected to receive less revenue from income taxation of Social Security benefits for all years beginning in 2025, and the timing for reserve depletion is accelerated by roughly one year. The 2026 Trustees Reports will reflect updated economic and demographic assumptions that incorporate the effects of the OBBBA as well as other factors and experience into the projections. As a result, the status of the HI trust fund that will be reported in the 2026 Medicare Trustees Report is uncertain at this time.

Similarly, the projections do not reflect the impact of the Medicare provisions in the *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026* (Public Law 119-37), which was enacted on November 12, 2025. The provisions included were temporary extensions of prior policies, a reduction in the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through February of 2033. The estimated impact is negligible over the next few years and there is no impact beyond 2033.

Lastly, the projections do not reflect the impact of the skin substitute policies finalized in the Calendar Year 2026 Physician Fee Schedule final rule, which was published on November 5, 2025. These policies significantly reduce spending for skin substitute services provided under Part B. Based on the projections reflected in the 2025 Medicare Trustees Report, the estimated impact on total Part B expenditures is a reduction of roughly 3.4 percent, including the reduction in fee-for-service spending and the associated impact on payments to Medicare Advantage plans, beginning in 2026.

and are expected to participate in the program as either taxpayers, beneficiaries, or both, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;

- The present value of future income (excluding interest) to be received from or on behalf of future participants and the expenditures of providing benefits to those same individuals;
- The present value of future income (excluding interest) less expenditures 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 income (excluding interest) less expenditures for all current and future participants over the next 75 years (open group measure) (deficit) increased from $(2.6) trillion, determined as of January 1, 2024, to $(3.3) trillion, determined as of January 1, 2025.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2025, the actuarial present value of estimated future income (excluding interest) less expenditures plus HI and SMI trust fund assets for all current and future participants is estimated to be a $(2.9) trillion deficit for the 75-year valuation period. The comparable metric for the closed group of participants is estimated to be a $(14.1) trillion deficit for the 75-year valuation period.

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 HI trust fund assets. 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. The ratio declines slightly from 40 percent at the beginning of FY 2021 to 39 percent at the beginning of FY 2022, after which it rises in 2023 through 2025. The ratio is estimated to increase in 2025 as a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.

Trust Fund Ratio Beginning of Fiscal Year [5]					
	2021	**2022**	**2023**	**2024**	**2025**
HI	40%	39%	45%	48%	53%

Short-Term Financing

The HI trust fund is deemed adequately financed for the short term when actuarial estimates of HI 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 2025 Medicare Trustees Report, after 2025 the HI trust fund ratio is estimated to steadily decrease for the rest of the projection period until the fund is depleted in CY 2033. The assets were $237.5 billion at the beginning of 2025, representing about 53 percent of expenditures projected for 2025, 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

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

Financial Summary and Highlights

This year's short-range financial outlook for the HI trust fund is less favorable than what was projected last year. After 2025, the trust fund ratio declines until the fund is depleted in CY 2033, three years earlier than projected in 2024. HI financing is not projected to be sustainable over the long-term with the projected tax rates and expenditure levels. Program expenditures are 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 be 89 percent in 2033 (year of exhaustion), 86 percent in 2049 (25th projection year), and then about 100 percent in 2099 (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 2024 to about 2.2 by 2099. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $3.1 trillion, which is 0.4 percent of taxable payroll and 0.2 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 expenditure 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 $(57.0) 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 percentage of GDP. In 2024, SMI incurred expenditures were 2.4 percent of GDP. By 2099, SMI expenditures are projected to grow to 4.8 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 HI trust fund's projected depletion, this fund's long-range financial imbalance, and the rapid growth in expenditures. The Medicare Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI and reduce the rate of growth in Medicare costs. The Trustees recommend that Congress and the executive branch work closely together to quickly address these challenges. The sooner solutions are enacted, the more flexible and gradual they can be. Introducing reforms early would give affected individuals and organizations–including health care providers, beneficiaries, and taxpayers–more time to adjust their expectations and behavior.

The following table presents key amounts from CMS's basic financial statements for FY 2025 found in the CMS FY 2025 AFR.

Table of Key Measures [6]

(in Billions)

		2025
Net Position (end of fiscal year)		
Assets	$	902.8
Less Total Liabilities		191.6
Net Position (assets net of liabilities)	**$**	**711.2**
Costs (end of fiscal year)		
Net Costs	$	1,691.2
Total Financing Sources		1,716.5
Net Change in Cumulative Results of Operations	**$**	**25.3**
Statement of Social Insurance (calendar year basis)		
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$	(3,301)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	$	(2,618)
Change in Present Value	**$**	**(683)**

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 (excluding interest) less future expenditures 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, 2025, decreased as follows: (i) by $97 billion as a result of advancing the valuation date by 1 year and including the additional year 2099, (ii) by $627 billion because of changes in the projection base; and (iii) by $236 billion because of changes in economic and health care assumptions. However, changes in the demographic assumptions increased the present value by $275 billion. The net overall impact of these changes is a decrease in the present value of $683 billion.

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

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 HI and SMI Medicare trust funds. 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 *2025 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 PRINCIPAL DEPUTY 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 PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

I am honored to join Secretary Kennedy in presenting the Fiscal Year (FY) 2025 Agency Financial Report (AFR), which reflects HHS's careful stewardship of the resources entrusted to us by the President, Congress, and the American people. Guided by our Chief Financial Officer (CFO) Community, HHS continued to strengthen fiscal accountability by enhancing efficiencies, eliminating wasteful spending, and expanding strong partnerships across the Department.

In FY 2025, the HHS CFO Community advanced operational efficiency by leading compliance with the President's Executive Orders (EO) and strengthening internal controls across program areas. Among other accomplishments, HHS:

- Exceeded the cost-savings targets in EO 14222, *Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative,* by achieving $16.3B in validated savings through HHS's Cost Efficiency Initiative.
- Published data on thousands of terminated grants and cancelled or descoped contracts, supporting the President's memorandum, *Radical Transparency About Wasteful Spending.*
- Modernized HHS's financial systems shared services portfolio through strategic cloud transformation, delivering over $30M in cost avoidance and $6.3M in annual savings.
- Streamlined over 200 Notices of Funding Opportunities, reducing complexity by over 20 percent and eliminating 1.8M extraneous words to ease applicant burden.
- Ensured compliance with EO 14247, *Modernizing Payments To and From America's Bank Account* and EO 14249, *Protecting America's Bank Account Against Fraud, Waste, and Abuse,* by driving increased use of Treasury's Do Not Pay system, reducing paper checks and lockboxes, ending HHS's nearly four-decades-long status as a non-Treasury disbursing office, and planning for financial systems consolidation.

We also implemented the revised OMB Circular A-136 requirement by presenting our FY 2025 financial statements in a single-year format. For the 27th 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. The auditors did not issue opinions on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. The Department's strong internal controls resulted in no auditor-reported material weaknesses for the eighth straight year.

I want to thank the HHS CFO Community and our partners for their efforts and collaboration throughout the fiscal year. This report reflects their tireless dedication to the HHS mission and the American people. Together, we will continue to enhance HHS's financial management capabilities and serve as accountable and committed stewards of the resources entrusted to us.

/Caitrin Shuy/

Caitrin Shuy
Principal Deputy Assistant Secretary for Financial Resources
January 14, 2026

Report of the Independent Auditors

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

January 14, 2026

TO: The Secretary

FROM: /John D. Hagg/
Acting Deputy Inspector General for Audit Services

SUBJECT: *Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2025*, OAS-25-17-071

This memo transmits the independent auditors' reports on the Department of Health and Human Services' (HHS) fiscal year (FY) 2025 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 (EY) to audit the HHS: (1) consolidated balance sheet as of September 30, 2025, and the related consolidated statements of net cost and changes in net position; (2) combined statement of budgetary resources for the year then ended; and (3) sustainability financial statements that comprise the statement of social insurance as of January 1, 2025, 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, EY found that the FY 2025 HHS consolidated balance sheet and the related consolidated statements of net cost and changes in net position, and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. EY was unable to obtain sufficient appropriate audit evidence for the amounts presented in the statements of social insurance as of January 1, 2025, 2024, 2023, 2022, and 2021, and the related statements of changes in social insurance amounts for the periods ended January 1, 2025, and 2024. As a result, EY was not able to, and did not, express an opinion on the sustainability financial statements for the specified periods.

EY noted two 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*, EY identified a series of issues that resulted in significant deficiencies related to HHS's (1) Financial Reporting Systems, Compliance, and Oversight; and (2) Insufficient Internal Controls to Mitigate Financial Reporting Risks. The firm provided associated recommendations. EY did not identify any deficiencies in internal control that it considered a material weakness.

EY also identified that HHS is not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (PIIA, P.L. No. 116-117). We will report further on agency compliance with improper payment reporting, as required by the PIIA, later in FY 2026. HHS management determined that HHS may have potential violations of the Antideficiency Act (31 U.S.C. chapters 13 and 15) related to past obligations and contract costs incurred, as well as potential violations of the Federal Acquisitions Regulations and Code of Federal Regulations.

Evaluation and Monitoring of Audit Performance

We reviewed EY'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
- Reviewing the HHS *FY 2025 Agency Financial Report*

EY 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 review, as limited to the procedures listed above, disclosed no instances in which EY 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 OAS-25-17-071.

Attachment

cc:
Gustav Chiarello
Assistant Secretary for
Financial Resources

Teresa Miranda
Deputy Assistant Secretary, Office of Finance
and HHS Deputy Chief Financial Officer

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Report of Independent Auditors

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

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 sheet as of September 30, 2025, and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources for the year 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, 2025, and the results of its net cost of operations, its changes in net position and its budgetary resources for the year 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, 2025, 2024, 2023, 2022 and 2021, and the related statement of changes in social insurance amounts for the periods ended January 1, 2025 and 2024, and the related notes (collectively referred to as the "sustainability financial statements").

We do not express an opinion on the accompanying sustainability financial statements of HHS. 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 audit 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

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(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 sheet as of September 30, 2025, and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources for the year 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 23 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).

With respect to the estimates for the social insurance program presented as of January 1, 2025, 2024, 2023, 2022 and 2021, 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 24, 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 appropriate audit evidence for the amounts presented in the statement of social insurance as of January 1, 2025, 2024, 2023, 2022 and 2021, and the related statement of changes in social insurance amounts for the years ended January 1, 2025 and 2024, and the related notes.

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 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 Principal Deputy Assistant Secretary for Financial Resources, Other Financial Information, Summary of Financial Statement Audit and Management Assurances, Grants Closeout Reporting, Payment Integrity Report, FY 2025 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 January 14, 2026 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.

Ernst & Young LLP

January 14, 2026

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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, 2025, 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 January 14, 2026 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, 2025, and the related statement of changes in social insurance amounts for the period ended January 1, 2025, and the related notes (collectively referred to as the "sustainability financial statements"), and our report dated January 14, 2026 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, Compliance and Oversight Significant Deficiency

Our review of internal control disclosed a series of deficiencies in financial systems, compliance and oversight controls. We identified the following items in the current year's audit.

Financial Adjustment Policy Implementation

As identified in 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 non-standard postings to record both the proprietary and budgetary effects of certain financial activities, including closing 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 and posting financial adjustments to standardize the process consistently across HHS, as well as establish oversight and monitoring efforts over entries deemed higher risk. In FY 2024, HHS issued interim guidance to assist Operating Divisions in standardizing and categorizing financial adjustments to comply with the Policy, with initial focus over the classification of entries as standard versus non-standard and recurring versus non-recurring in an effort to risk-assess the large population journal vouchers. In FY 2025, HHS made significant progress in implementing and evaluating compliance with the Policy among accounting centers, identifying populations of transactions and analyzing those transactions to provide timely feedback on the accuracy of adjustment classification

tagged by the Operating Division. As part of our procedures, we identified that Divisions do not have sufficient monitoring procedures to conduct a comprehensive analysis of their non-standard manual journal entry population, as a whole, that would assist with reducing risks of inaccurate, untimely and incomplete financial information.

Inadequate Controls Over Compliance with Laws and Regulations

FMFIA requires agencies to have adequate controls to provide reasonable assurance that obligations and contracts are in compliance with applicable laws. HHS lacks adequate internal controls to assess compliance with the *Antideficiency Act* (ADA) and procurement regulations in a timely manner which has led to untimely discovery and reporting of the agency's compliance. Specifically:

- We have reported that HHS identified a series of potential violations to the ADA in our Report on Compliance and Other Matters section below. In certain cases, those potential violations were identified several years ago, and HHS management is still in the process of making a final determination on compliance.

- HHS Office of Inspector General (OIG) reported that the 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.

- In FY 2025, OIG reported that the Administration for Children and Families (ACF) did not award, monitor and close selected contracts in accordance with the requirements of the Federal Acquisition Regulation (FAR) and HHS policies and procedures. Additionally, ACF incurred potentially unallowable costs that could lead to potential ADA violations. ACF concurred with the findings and has begun the process of taking corrective actions.

Centers for Medicare & Medicaid Services (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 January 12, 2026. 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 (EBDP)

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 fiscal year 2025, 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 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 liability as of year-end, as required by Statement of Federal Financial Accounting Standards No. 5, *Accounting for Liabilities of the Federal Government*, 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 2025 financial statements and is subject to volatility. 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.

Statement of Social Insurance

The Statement of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The 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 models, 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 models are 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 models or Excel macro programs to ensure that the projection output from the programs are as expected and reasonable.

The Government Accountability Office (GAO)'s *Standards for Internal Control in the Federal Government* indicate that management should design control activities to achieve objectives and respond to risks. However, during our audit procedures of the SOSI, we identified that documentation evidencing the review of inputs/outputs were not sufficiently precise. Additionally, formula errors were identified that were not detected by the organization's monitoring and review function, and, accordingly, the related internal control was not functioning at the level of precision as designed. Inadequate review procedures may result in errors within the SOSI models and could lead to misstatements within the SOSI financial statements and related footnotes.

Recommendations

We recommend that HHS continue to develop, refine, and adhere to its financial management policies 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 Divisions' comprehensive review of financial adjustment classifications align with the Financial Adjustments Policy. Further, HHS should coordinate with Divisions to validate and document the completeness of the overall manual journal entry population as well as the accuracy of the non-standard journal entry population. Lastly, HHS should continue to identify root causes of non-standard journal entries and assess potential process enhancements to reduce their occurrence.

- HHS should continue to strengthen its processes related to acquisition activities. As potential internal control weaknesses and potential violations of new laws and regulations 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 and ACF should continue to implement corrective actions to provide for contract closeout in accordance with federal requirements. Finally, HHS should establish a process to evaluate whether pending ADA violations are reportable and report those items that are declared on a timely basis.

- 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 utilized to record this 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 to ensure the completeness and accuracy of the models and the related financial statements. When changes are made to the SOSI models, such as changes to the methodology or key assumptions, management should require an enhanced review specific to these changes.

Insufficient Internal Controls to Mitigate Financial Reporting Risks Significant Deficiency

The GAO's Standards for Internal Control in the Federal Government (Green Book) indicates that internal control is a process effected by an entity's oversight body, management and other personnel designed to provide reasonable assurance that the objectives of an entity will be achieved. As part of our procedures, we noted instances where documentation to support the design or operation of controls addressing financial reporting risks were lacking, not sufficient or were outdated.

During FY 2025, HHS initiated a restructuring of the organization resulting in significant turnover of personnel. Many of these changes came with limited advance notice, reducing the ability to provide adequate transitions between personnel. The lack of adequate transition planning, coupled with the lack of sufficient documentation of the design and operation of financial reporting controls, led to the following findings over financial activities.

Insufficient documentation of control environment

As part of our audit procedures, we noted instances within the Commissioned Corps Liability and Procurement cycles where evidence of the execution of controls lacked sufficient documentation to support activities. Further, we identified certain instances within the Grants cycle where controls were not identified or implemented across all Divisions.

As part of our procedures performed over the Commissioned Corps Liability cycle, we noted that many personnel responsible for key controls were no longer in those roles due to HHS's reorganization, turnover or reductions in force. In some instances, new control owners were not timely trained or equipped with adequate standard operating procedures (SOP) or up-to-date process narratives to address inquiries and requests related to the execution of their duties and/or related internal controls, including judgmental or subjective aspects of the design and execution of the control.

As part of our procedures over the Procurement cycle, we noted the process narratives did not contain supplemental information to detail current control activities, which coupled with the inability to inquire of control owners due to reorganization contributed to HHS's difficulty in providing explanations for the evidence received.

As part of our procedures over the Grants process, we identified instances where three Divisions authorized Grants Management System users to perform multiple functions (Grant Management Officer, Program Officer and/or Peer Review) that should be monitored by compensating controls when combined. While access to multiple roles may be appropriate, these Divisions did not document processes or identify compensating detect controls to address or monitor the segregation of duties financial reporting risk.

These limitations impacted management's ability to perform adequate monitoring and evaluation procedures to ensure controls are designed, implemented and operating effectively, as required by the GAO Green Book.

Lack of Adequate Process Documentation for Newly Developed Controls

In response to a series of FY 2025 Executive Orders, HHS modified systems and processes for awarding and approving grants and related payments. Modifications to HHS systems were implemented to support governmentwide initiatives for grant payment transparency, and process enhancements were made by HHS and its Divisions to support these efforts. While the system guidance was available, the process documentation and related guidance were insufficient. The guidance lacked minimum requirements for determining the reasonableness of payments, clearly defined roles and responsibilities, and comprehensive policies and procedures. Per HHS, many of the related critical process decisions were communicated informally through email, rather than through formal channels due to the required implementation timing, and management asserted that it had not received the necessary approval to develop formal guidance for Department-wide distribution.

Without contingency plans in place, lack of available transition resources related to control activities or system implementations, and outdated or incomplete process narratives, management is unable to review policies, procedures, and related control activities on a periodic and ongoing basis for continued relevance and effectiveness in achieving the entity's objectives or mitigating related risks, as required by the GAO Green Book.

OMB Circular A-123 Program

To support federal agencies' required assertions under FMFIA, OMB issued Circular A-123, *Management's Responsibility for 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 (SOA) 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.

Each Division utilizes controls deficiency logs to summarize internal control deficiencies identified during the OMB Circular A-123 testing activities. We identified instances where the Administration for Community Living (ACL) did not provide a control deficiency log to support their SOA, and Agency for Healthcare Research and Quality (AHRQ) reported significant deficiencies within its control deficiency log, but not within its SOA. The absence of monitoring controls over reported control deficiencies at the Division level may result in inaccurate internal control reporting.

Recommendations

We recommend that HHS and its Divisions:

- Establish policies and procedures to routinely update process-level documentation to ensure it reflects current control design activities and system environment and is at the appropriate level of detail to allow management to effectively monitor the control activities and address financial reporting risks.

- Enhance policies and procedures to formally retain evidence of control activities, including subjective decisions made during control execution, to ensure adequate documentation is available to support internal control evaluations and monitoring.

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

- Ensure accuracy of SOA's and enhance the monitoring efforts over reported control deficiency logs.

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.

Antideficiency Act

HHS's management determined that it may have potential violations of the ADA (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, (2) certain contract obligations serviced by the PSC between FY 2006 and FY 2011, and (3) certain contract costs incurred outside of the period of performance at the Administration for Children and Families (ACF). Additionally, PSC, NIH and ACF management were notified that they may have potential violations of the Federal Acquisition Regulations and the Code of Federal Regulations related to contracting matters. These potential violations are still being evaluated.

Payment Integrity Information Act of 2019

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. Given the large number of unique programs administered by HHS, the nature and volume of expenditures present a substantial challenge to HHS in the quantification, evaluation and remediation of improper payments. Additionally, 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 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.

To address the challenges noted above, 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. HHS remains committed to achieving reductions in all improper payment rates through various corrective actions. While the Department continues to make progress, HHS is not in full compliance with the requirements of the PIIA. For example:

- During FY 2025, the Department performed 97 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 97 programs were assessed in FY 2025 and a total of 242 were assessed in the three-year period ended FY 2025, knowledge about potential susceptibility to significant improper payments may not be fully realized. PIIA requires each agency to perform a risk assessment not less frequently than once every three fiscal years for each program and outlay 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 2026.

- HHS has developed, executed and reported improper payments for 9 of its 10 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.

- From FY 2020 to FY 2023, we reported that ACF had not calculated or published error rates for its Foster Care program. This was due to a 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 its on-site reviews and testing for improper payments and performed reviews at six states judgmentally selected based on the date of the last review and other criteria. In FY 2025, twenty states were newly added and an improper payment rate was reported within the *Other Information* section of this FY 2025 HHS Agency Financial Report. HHS represented to us that the improper payment estimate would not encompass the full population of states until FY 2026.

- The ACF Office of Head Start annually awards over $10 billion in federal grants to approximately 1,800 recipients. In FY 2025, HHS reported that the Head Start program had an improper payment estimate above the PIIA statutory threshold of 10% of 10.29%. ACF reported that the majority of the improper payments related to missing or insufficient documentation to substantiate certain payments.

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

While management continues to implement corrective actions to reduce the improper payment rates for all programs, even those below the statutory threshold of 10%, the rates for the Medicare Part C, Medicare Part D, Medicaid and CHIP programs increased from the prior year.

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 January 14, 2026. 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

January 14, 2026

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: T. March Bell, Inspector General

From: Caitrin Shuy, Principal Deputy Assistant Secretary for Financial Resources

Subject: Fiscal Year 2025 Independent Auditors' Financial Statement Audit Reports

We appreciate the opportunity to provide responses on the Fiscal Year 2025 Independent Auditors' Reports. The Office of Inspector General (OIG) and its independent auditors, Ernst & Young, LLP (EY), demonstrated a high level of professionalism and diligence throughout their review of the Department of Health and Human Services's (HHS) financial statements. We value and respect their continued partnership in facilitating HHS's commitment to strengthen fiscal stewardship, oversight, and accountability.

We are pleased the auditors affirmed the Department's financial position with an unmodified opinion on our principal financial statements. The auditors did not issue opinions 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 remain committed to mitigating the underlying root causes of the identified deficiencies through targeted, sustainable corrective actions.

This year's audit results underscore the progress highlighted in our FY 2025 Agency Financial Report. Through the leadership of our CFO Community, the Department advanced financial system modernization, strengthened enterprise-wide internal controls and implemented additional reviews to ensure compliance with Executive Orders. These efforts improve data integrity, bolster stewardship of federal resources, reduce wasteful spending, drive meaningful operational improvements, and overall support our mission delivery.

We extend our sincere appreciation to the OIG and EY for their collaboration and constructive engagement throughout the audit. Our shared commitment to transparency, accountability, and continuous improvement remains unwavering. We look forward to continuing our joint efforts to strengthen the Department's internal control framework and enhance the overall effectiveness of our operations as we work to advance fiscal accountability for a healthy America.

/Caitrin Shuy/

Caitrin Shuy
Principal Deputy Assistant Secretary for Financial Resources
January 14, 2026

Principal Financial Statements

U.S. Department of Health and Human Services

Consolidated Balance Sheet

As of September 30, 2025

(in Millions)

		2025
Assets (Note 2)		
Intragovernmental Assets:		
Fund Balance with Treasury (Note 3)	$	659,351
Investments, Net (Note 4)		414,323
Accounts Receivable, Net (Note 5)		763
Advances and Prepayments (Note 8)		1,966
Total Intragovernmental Assets		**1,076,403**
Other than Intragovernmental Assets:		
Accounts Receivable, Net (Note 5)		49,212
Inventory and Related Property, Net (Note 6)		19,183
Property, Plant and Equipment, Net (Note 7)		9,391
Advances and Prepayments (Note 8)		118
Other Assets:		
Loans Receivable, Net		377
Other		9
Total Other than Intragovernmental Assets		**78,290**
Total Assets	$	**1,154,693**
Stewardship Land (Note 20)		
Liabilities (Note 9)		
Intragovernmental Liabilities:		
Accounts Payable	$	1,099
Debt		452
Advances from Others and Deferred Revenue		500
Other Liabilities (Note 13)		1,720
Total Intragovernmental Liabilities		**3,771**
Other than Intragovernmental Liabilities:		
Accounts Payable		1,443
Entitlement Benefits Due and Payable (Note 10)		163,952
Federal Employee Salary, Leave and Benefits Payable (Note 11)		1,374
Pensions and Post-Employment Benefits Payable (Note 11)		22,567
Environmental and Disposal Liabilities		229
Advances from Others and Deferred Revenue		4,365
Other Liabilities:		
Accrued Liabilities (Note 12)		18,042
Contingencies and Commitments (Note 14)		17,785
Other Liabilities (Note 13)		1,426
Total Other than Intragovernmental Liabilities		**231,183**
Total Liabilities		**234,954**
Net Position		
Unexpended Appropriations – Funds from Dedicated Collections (Note 19)		236,903
Unexpended Appropriations – Funds from Other Than Dedicated Collections		297,983
Total Unexpended Appropriations		**534,886**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 19)		373,853
Cumulative Results of Operations – Funds from Other Than Dedicated Collections		11,000
Total Cumulative Results of Operations		**384,853**
Total Net Position		**919,739**
Total Liabilities and Net Position	$	**1,154,693**

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

Principal Financial Statements

U.S. Department of Health and Human Services
Consolidated Statement of Net Cost

For the Years Ended September 30, 2025

(in Millions)

		2025
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Cost	$	1,867,923
Earned Revenue		(176,901)
CMS Net Cost of Operations		1,691,022
Other Segments:		
Administration for Children and Families (ACF)		76,120
Administration for Community Living (ACL)		3,057
Agency for Healthcare Research and Quality (AHRQ)		351
Administration for Strategic Preparedness and Response (ASPR)		1,073
Centers for Disease Control and Prevention (CDC)		17,900
Food and Drug Administration (FDA)		6,945
Health Resources and Services Administration (HRSA)		14,912
Indian Health Service (IHS)		10,924
National Institutes of Health (NIH)		48,930
Office of the Secretary (OS)		12,544
Program Support Center (PSC)		2,837
Substance Abuse and Mental Health Services Administration (SAMHSA)		8,316
Other Segments Gross Cost of Operations before Actuarial Gains and Losses		203,909
Actuarial (Gains) and Losses Commissioned Corps Retirement and Medical Plan Assumption Changes (Note 11)		496
Other Segments Gross Cost of Operations after Actuarial Gains and Losses		204,405
Earned Revenue		(8,221)
Other Segments Net Cost of Operations		196,184
Net Cost of Operations (Note 21)	**$**	**1,887,206**

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

Principal Financial Statements

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

For the Year Ended September 30, 2025

(in Millions)

	Funds from Dedicated Collections (Note 19)	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations				
Beginning Balance	$ 263,916	$ 319,995	$ -	$ 583,911
Appropriations Received	657,934	932,858	-	1,590,792
Appropriations Transferred in/out	-	(1,472)	-	(1,472)
Other Adjustments	(75,243)	(66,743)	-	(141,986)
Appropriations Used	(609,704)	(886,655)	-	(1,496,359)
Net Change in Unexpended Appropriations	(27,013)	(22,012)	-	(49,025)
Total Unexpended Appropriations	**$ 236,903**	**$ 297,983**	**$ -**	**$ 534,886**
Cumulative Results of Operations				
Beginning Balance	$ 348,049	$ 10,738	$ -	$ 358,787
Appropriations Used	609,704	886,655	-	1,496,359
Nonexchange Revenue:				
Nonexchange Revenue – Tax Revenue	400,622	-	-	400,622
Nonexchange Revenue – Investment Revenue	12,521	1,056	-	13,577
Nonexchange Revenue – Other	3,224	131	-	3,355
Donations and Forfeitures of Cash and Cash Equivalents	43	-	-	43
Transfers in/out without Reimbursement	(5,824)	4,265	-	(1,559)
Donations and Forfeitures of Property	-	11	-	11
Imputed Financing	1,318	1,618	(440)	2,496
Other	15	(1,647)	-	(1,632)
Net Cost of Operations	995,819	891,827	(440)	1,887,206
Net Change in Cumulative Results of Operations	25,804	262	-	26,066
Total Cumulative Results of Operations	**$ 373,853**	**$ 11,000**	**$ -**	**$ 384,853**
Net Position	**$ 610,756**	**$ 308,983**	**$ -**	**$ 919,739**

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

Principal Financial Statements

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources

For the Years Ended September 30, 2025

(in Millions)

		2025
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory) (Note 15)	$	387,756
Appropriations (Discretionary and Mandatory)		2,695,918
Spending Authority from Offsetting Collections (Discretionary and Mandatory)		46,071
Total Budgetary Resources	**$**	**3,129,745**
New Obligations and Upward Adjustments	$	2,794,363
Unobligated Balance, End of Year		
Apportioned, Unexpired Accounts		67,232
Exempt from Apportionment, Unexpired Accounts		1,234
Unapportioned, Unexpired Accounts		18,397
Unexpired Unobligated Balance, End of Year		86,863
Expired Unobligated Balance, End of Year		248,519
Unobligated Balance, End of Year		335,382
Total Budgetary Resources	**$**	**3,129,745**
Outlays, Net (Discretionary and Mandatory)	$	2,671,374
Distributed Offsetting Receipts		(786,930)
Agency Outlays, Net (Discretionary and Mandatory) (Note 21)	**$**	**1,884,444**
Disbursements, Net	**$**	**(134)**

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

Principal Financial Statements

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

75-Year Projection as of January 1, 2025 and Prior Base Years
(in Billions)

	2025	Estimates from Prior Years 2024	2023	2022	2021
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 23 and 24)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 16,554	$ 16,189	$ 15,360	$ 14,767	$ 13,029
SMI Part B	47,167	40,323	39,008	39,039	34,467
SMI Part D	6,910	7,097	6,865	7,372	6,881
Have attained eligibility age (age 65 or over)					
HI	1,042	953	862	793	664
SMI Part B	9,517	8,181	7,683	7,447	6,536
SMI Part D	1,592	1,517	1,315	1,164	1,061
Those expected to become participants					
HI	15,537	15,360	15,046	14,603	13,017
SMI Part B	11,845	10,161	9,934	10,131	9,010
SMI Part D	2,231	2,393	2,372	3,094	2,921
All current and future participants					
HI	$ 33,133	$ 32,502	$ 31,268	$ 30,163	$ 26,710
SMI Part B	68,530	58,665	56,625	56,618	50,013
SMI Part D	10,733	11,008	10,551	11,630	10,863
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 23 and 24)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 23,964	$ 22,970	$ 23,622	$ 23,211	$ 20,940
SMI Part B	46,832	39,853	38,539	38,605	34,075
SMI Part D	6,910	7,097	6,865	7,372	6,881
Have attained eligibility age (age 65 and over)					
HI	8,045	7,357	7,215	7,010	6,230
SMI Part B	9,980	8,508	8,038	7,825	6,892
SMI Part D	1,592	1,517	1,315	1,164	1,061
Those expected to become participants					
HI	4,426	4,794	5,061	5,036	4,597
SMI Part B	11,717	10,304	10,048	10,188	9,046
SMI Part D	2,231	2,393	2,372	3,094	2,921
All current and future participants:					
HI	$ 36,435	$ 35,120	$ 35,897	$ 35,257	$ 31,767
SMI Part B	68,530	58,665	56,625	56,618	50,013
SMI Part D	10,733	11,008	10,551	11,630	10,863
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 23 and 24)					
HI	$ (3,301)	$ (2,618)	$ (4,630)	$ (5,094)	$ (5,057)
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 23 and 24)					
HI	$ (3,301)	$ (2,618)	$ (4,630)	$ (5,094)	$ (5,057)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	237	209	198	177	198
SMI Part B	152	172	194	163	133
SMI Part D	19	16	18	20	10
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 23 and 24)					
HI	$ (3,064)	$ (2,410)	$ (4,432)	$ (4,917)	$ (4,859)
SMI Part B	152	172	194	163	133
SMI Part D	19	16	18	20	10

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.

Principal Financial Statements

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

75-Year Projection as of January 1, 2025 and Prior Base Years
(in Billions)

	2025	Estimates from Prior Years 2024	2023	2022	2021
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)	$ 12,152	$ 10,651	$ 9,860	$ 9,404	$ 8,261
Expenditures	19,617	17,383	16,567	15,998	14,184
Income less expenditures	(7,465)	(6,731)	(6,707)	(6,595)	(5,922)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	70,631	63,609	61,232	61,178	54,377
Expenditures	77,706	69,920	69,026	69,188	61,895
Income less expenditures	(7,075)	(6,310)	(7,794)	(8,010)	(7,519)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(14,540)	(13,042)	(14,501)	(14,605)	(13,441)
Combined Medicare Trust Fund assets at start of period	408	397	410	360	341
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (14,132)	$ (12,645)	$ (14,091)	$ (14,244)	$ (13,100)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	$ 29,613	$ 27,914	$ 27,352	$ 27,828	$ 24,948
Expenditures	18,374	17,491	17,480	18,318	16,564
Income less expenditures	11,239	10,423	9,871	9,510	8,384
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,301)	(2,618)	(4,630)	(5,094)	(5,057)
Combined Medicare Trust Fund assets at start of period	408	397	410	360	341
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (2,893)	$ (2,222)	$ (4,220)	$ (4,734)	$ (4,716)

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.

Principal Financial Statements

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

January 1, 2024 to January 1, 2025

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 25)					
As of January 1, 2024	$ 102,175	$ 104,793	$ (2,618)	$ 397	$ (2,222)
Reasons for change					
Change in the valuation period	3,319	3,416	(97)	22	(75)
Change in projection base	1,737	2,364	(627)	(11)	(638)
Changes in the demographic assumptions	(1,361)	(1,637)	275	-	275
Changes in economic and health care assumptions	6,487	6,723	(236)	-	(236)
Changes in law	39	37	2	-	2
Net changes	10,221	10,904	(683)	11	(672)
As of January 1, 2025	$ 112,396	$ 115,697	$ (3,301)	$ 408	$ (2,893)
HI - Part A (Note 25)					
As of January 1, 2024	$ 32,502	$ 35,120	$ (2,618)	$ 209	$ (2,410)
Reasons for change					
Change in the valuation period	962	1,059	(97)	24	(73)
Change in projection base	62	689	(627)	5	(622)
Changes in the demographic assumptions	(304)	(579)	275	-	275
Changes in economic and health care assumptions	(89)	147	(236)	-	(236)
Changes in law	-	(2)	2	-	2
Net changes	632	1,315	(683)	29	(654)
As of January 1, 2025	$ 33,133	$ 36,435	$ (3,301)	$ 237	$ (3,064)
SMI - Part B (Note 25)					
As of January 1, 2024	$ 58,665	$ 58,665	$ -	$ 172	$ 172
Reasons for change					
Change in the valuation period	2,025	2,025	-	(3)	(3)
Change in projection base	1,614	1,614	-	(18)	(18)
Changes in the demographic assumptions	(675)	(675)	-	-	-
Changes in economic and health care assumptions	6,861	6,861	-	-	-
Changes in law	40	40	-	-	-
Net changes	9,864	9,864	-	(21)	(21)
As of January 1, 2025	$ 68,530	$ 68,530	$ -	$ 152	$ 152
SMI - Part D (Note 25)					
As of January 1, 2024	$ 11,008	$ 11,008	$ -	$ 16	$ 16
Reasons for change					
Change in the valuation period	333	333	-	-	-
Change in projection base	61	61	-	3	3
Changes in the demographic assumptions	(383)	(383)	-	-	-
Changes in economic and health care assumptions	(285)	(285)	-	-	-
Changes in law	-	-	-	-	-
Net changes	(275)	(275)	-	3	3
As of January 1, 2025	$ 10,733	$ 10,733	$ -	$ 19	$ 19

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.

Principal Financial Statements

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Continued) (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 25)					
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 health care 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 25)					
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 health care 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 25)					
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 health care 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 25)					
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 health care 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.

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 enhancing 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.

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 Divisions 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 Division 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 Divisions. 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. 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 Division, 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 223 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 Sheet, Statement 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 Divisions, 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 health care 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, Labor (DOL), and Treasury.

G. Changes, Reclassifications and Adjustments

Change

Effective FY 2025, the principal statements and footnotes have changed to a single-year presentation format.

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.

Federal Medicare Hospital Insurance Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Federal 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 trust 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.

Federal Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Federal 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 trust 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 Health Care 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.

Federal 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 Health Care 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 Statement 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. Custodial Activity

HHS reports custodial activities on its Consolidated Balance Sheet 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.

L. Fund Balance with Treasury

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. 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 five 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.

N. 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 that transfer ownership, 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.

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 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, 2026, 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.

O. 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.

P. 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.

Q. 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 Sheet. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end on the Statement of Net Cost.

Pensions and 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 two 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 Sheet 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 Statement of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

R. 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 procedures, 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.

S. 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)

		2025
Non-Entity Intragovernmental Assets	$	22
Non-Entity Other than Intragovernmental Assets		72
Total Non-Entity Assets		94
Total Entity Assets		1,154,599
Total Assets	**$**	**1,154,693**

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.

Note 3. Fund Balance with Treasury (in Millions)

		2025
Status of Fund Balance with Treasury		
Unobligated Balance	$	335,382
Obligated Balance not yet Disbursed		398,658
Non-Budgetary Fund Balance with Treasury		(74,689)
Total Fund Balance with Treasury	**$**	**659,351**

The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $54.8 billion as of September 30, 2025. The restricted amount is primarily for CHIP, CMS Program Management, Center for Medicare and Medicaid Innovation, and State Grants and Demonstrations.

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)

	2025				
	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 406,751	$ -	$ 2,987	$ 409,738	$ 409,738
Non-Marketable: Market-Based	4,511	53	21	4,585	4,585
Total Intragovernmental	**$ 411,262**	**$ 53**	**$ 3,008**	**$ 414,323**	**$ 414,323**

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, 2027 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, 2026 with an interest rate from 4.250 percent to 4.500 percent.

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. 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 4.625 percent during October 1, 2024 to September 30, 2025. The Market-Based Bonds pay 5.375 percent through FY 2031.

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. The Non-Marketable Market-Based Securities held in the NIH gift funds yielded rates ranging from 4.119 percent to 4.561 percent from October 1, 2024 through September 30, 2025 depending on date purchased and length of time to maturity.

Note 5. Accounts Receivable, Net (in Millions)

	2025				
	Accounts Receivable, Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 763	$ -	$ 763	$ -	$ 763
Total Intragovernmental	**$ 763**	**$ -**	**$ 763**	**$ -**	**$ 763**
Other than Intragovernmental					
Entity					
Medicare	$ 37,445	$ -	$ 37,445	$ (5,689)	$ 31,756
Medicaid	7,917	-	7,917	(847)	7,070
Other	12,064	508	12,572	(2,258)	10,314
Non-Entity	17	169	186	(114)	72
Total Other than Intragovernmental	**$ 57,443**	**$ 677**	**$ 58,120**	**$ (8,908)**	**$ 49,212**

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

	2025
Inventory Held for Sale or Use	$ 2,540
Stockpile Materials Held for Emergency or Contingency	16,643
Total Inventory and Related Property, Net	**$ 19,183**

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

Stockpile Materials Held for Emergency or Contingency are held 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) established Vendor Managed Inventories and Vaccines for Children (VFC). These stockpiles contain millions of units of vaccines, antibiotics, antitoxins, antivirals, chemical antidotes and other lifesaving medical material or devices stored and maintained in both finished forms and bulk drug substance for deployment and use as needed.

The Administration for Strategic Preparedness and Response has increased the preparedness of the nation by procuring medical countermeasures including anthrax vaccine, and, antitoxins, botulin antitoxins, vaccines and antivirals for smallpox and Ebola virus, treatments for exposure to nerve agents and other chemical threats, and treatments for injuries that would arise from radiological and nuclear events. These actions are possible through BARDA investment of Project BioShield funding and through SNS procurement, management and deployment of commercial and non-commercial medical countermeasures for identified Chemical, Biological, Radiological, Nuclear and Explosive threats, and other pandemic and emerging infectious diseases. 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.

Inventory Held for Sale or Use includes Inventories Held for Sale and Operating Material and Supplies. Inventories Held for Sale consist 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.

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.

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

			2025		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	N/A	N/A	$ 71	$ (8)	$ 63
Construction in Progress	N/A	N/A	3,114	-	3,114
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	7,739	(4,652)	3,087
Equipment	Straight-Line	3-20 Yrs	2,021	(1,079)	942
Internal Use Software	Straight-Line	5-10 Yrs	6,559	(4,911)	1,648
Assets that Transfer Ownership	Straight-Line	1-30 Yrs	46	(37)	9
Leasehold Improvements	Straight-Line	*Life of Lease	52	(25)	27
Right-to-Use Lease	Straight-Line	*Life of Lease	556	(55)	501
Total			**$ 20,158**	**$ (10,767)**	**$ 9,391**

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

	2025		
	Acquisition Cost	Accumulated Depreciation	PP&E, Net
Balance Beginning of Year	$ 19,623	$ (10,356)	$ 9,267
Capitalized Acquisitions	1,282	-	1,282
Right-to-Use Lease Assets	(258)	(6)	(264)
Dispositions	(489)	566	77
Depreciation Expense	-	(971)	(971)
Balance End of Year	**$ 20,158**	**$ (10,767)**	**$ 9,391**

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 health care services.

Note 8. Advances and Prepayments (in Millions)

	2025
Intragovernmental	
Advances to Other Federal Entities	$ 1,966
Total Intragovernmental	**$ 1,966**
Other than Intragovernmental	
Grant Advances	$ 22
Other	96
Total Other than Intragovernmental	**$ 118**

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

		2025
Intragovernmental		
Accrued Payroll and Benefits	$	49
Debt		94
Other		1,586
Total Intragovernmental	**$**	**1,729**
Other than Intragovernmental		
Federal Employee Salary, Leave and Benefits Payable	$	919
Pensions and Post-Employment Benefits Payable		22,565
Contingencies and Commitments (Note 14)		17,785
Accrued Liabilities		9,809
Unfunded Lease Liability		535
Other		238
Total Other than Intragovernmental	**$**	**51,851**
Total Liabilities Not Covered by Budgetary Resources	$	53,580
Total Liabilities Covered by Budgetary Resources		176,145
Total Liabilities Not Requiring Budgetary Resources		5,229
Total Liabilities	**$**	**234,954**

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.

Note 10. Entitlement Benefits Due and Payable (in Millions)

		2025
Medicare Fee-For-Service	$	64,352
Medicare Advantage/Prescription Drug Program		40,343
Medicaid		57,979
CHIP		1,278
Total Entitlement Benefits Due and Payable	**$**	**163,952**

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 incurred but not reported (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, 2025 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 2025. 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, 2025.

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, 2025.

Note 11. Federal Employee Benefits Payable (in Millions)

		2025
Federal Employee Salary, Leave and Benefits Payable		
Unfunded Leave	$	919
Accrued Funded Leave and Payroll		451
Other		4
Total Federal Employee Salary, Leave and Benefits Payable	**$**	**1,374**
Pensions and Post-Employment Benefits Payable		
PHS Commissioned Corps Pension Liability	$	21,316
PHS Commissioned Corps Post-Retirement Health Benefits		1,028
Workers' Compensation Benefits (Actuarial FECA Liability)		221
Other		2
Total Pensions and Post-Employment Benefits Payable	**$**	**22,567**

Public Health Service Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 5,191 active-duty officers, 80 individual ready reserve members, and 8,397 retiree annuitants and survivors. As of September 30, 2025, the actuarial accrued liability for the retirement benefit plan was $21.3 billion and $1.0 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

Notes to the Principal Financial Statements

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, 2025, were:

	2025
Discount Rate	3.20 percent
Annual Basic Pay Scale Increase	2.54 percent
Annual Inflation	2.64 percent

The table shows key valuation results as of September 30, 2025, in conformance with the actuarial reporting standards set forth in SFFAS 5 and SFFAS 33. The valuation is based upon the current plan provisions, membership data collected as of September 30, 2025, and actuarial assumptions. The September 30, 2025 valuation includes an increase in liabilities of $1.5 billion resulting from changes in the assumed annual inflation rate and in the assumed salary scale. 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 2025 has decreased relative to the prior year expense.

		2025
Beginning Liability Balance	$	20,882
Expense:		
Normal Cost		554
Interest on the Liability Balance		655
Actuarial (Gain)/Loss		
From Experience		536
From Assumption Changes		
Change in Inflation/Salary Increase Assumption		251
Change in Experience Study Assumption		114
Change in New Medical Trends Assumption		90
Change in Others		41
Total From Assumption Changes	$	496
Net Actuarial (Gain)/Loss		1,032
Total Expense	$	2,241
Less Amounts Paid		(779)
Ending Liability Balance	**$**	**22,344**

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 FY 2025, 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	
	2025
Wage Benefits	3.221% in Year 1 and years thereafter
Medical Benefits	2.944% 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:

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
COLA	N/A	4.35%	4.05%	3.05%	2.45%	2.26%	2.20%	2.23%	2.21%	2.20%	2.20%
CPI-M	N/A	2.54%	2.90%	3.06%	3.66%	3.84%	3.89%	3.87%	3.86%	3.86%	3.85%

Note 12. Accrued Liabilities (in Millions)

		2025
Grant Liability	$	4,340
Other Accrued Liabilities		13,702
Total Accrued Liabilities	**$**	**18,042**

HHS recognizes grant expenses at the time of payment to the grant recipients. The accrual includes the 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 Division. The expenses are recorded as the grantees draw funds; no year-end accrual is required.

Note 13. Other Liabilities (in Millions)

		2025
Intragovernmental		
Legal Liabilities	$	1,224
Benefit Program Contribution Payable		138
Custodial Liabilities		330
Other		28
Total Intragovernmental	**$**	**1,720**
Other than Intragovernmental		
Custodial Liabilities	$	11
Lease Liability		536
Other		879
Total Other than Intragovernmental	**$**	**1,426**

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 14. 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. HHS does not record an accrual for a contingent liability if it is not estimable and probable, but does disclose those contingencies in the financial statements, if the future settlement could be material to the financial statements. Selected contingencies and commitments are described below.

Medicaid Audit and Program Disallowances and Legal Contingencies

The amount of $8.2 billion as of September 30, 2025 consists of $5.9 billion for Medicaid audit and program disallowances, reimbursement of state plan amendments and $2.3 billion for legal contingent liabilities. 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, 2025.

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

		2025
Unobligated Balance, End of Year (from Prior Year)	$	345,826
Adjustments to Unobligated Balance Brought Forward:		
Recoveries of Prior Year Unpaid Obligations		69,589
Recoveries of Prior Year Paid Obligations		22,823
Appropriation Withdrawn		(4,277)
Appropriation Temporarily Precluded from Obligation - Prior Year		(11)
Cancelled Authority		(46,049)
Prior Year Adjustments		120
Other		(265)
Total Unobligated Balance Brought Forward, October 1	**$**	**387,756**

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.

Cancelled Authority of $46.0 billion is primarily due to the return of the cancelled year authority to Treasury, which included $43.8 billion for PTF and $2.0 billion for CHIP.

HHS had $4.3 billion in Appropriation Withdrawn, which primarily represents the return of prior year indefinite authority related to Medicare premium matching for repayment of repayable advance.

Note 16. 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 $305.5 billion, as of September 30, 2025 are included in Investments on the Consolidated Balance Sheet.

Note 17. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

	2024			
	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 2,864,571	$ 2,518,745	$ 700,865	$ 2,421,864
Expired Accounts	(264,893)	-	-	-
Other	(1)	(5)	301	(4)
Budget of the U.S. Government	**$ 2,599,677**	**$ 2,518,740**	**$ 701,166**	**$ 2,421,860**

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2025, has not been published; therefore, no comparisons can be made between FY 2025 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2027 President's Budget* is expected to be released in February 2026 and may be obtained from OMB (unaudited) or from the Government Publishing Office (unaudited).

HHS reconciled the amounts of the FY 2024 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2024 from the Appendix in the *FY 2026 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 18. Undelivered Orders (in Millions)

	2025		
	Federal	Non-Federal	Total
Undelivered Orders, Paid	$ 1,307	$ 1,275	$ 2,582
Undelivered Orders, Unpaid	11,244	215,713	226,957
Total Undelivered Orders	**$ 12,551**	**$ 216,988**	**$ 229,539**

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 $229.5 billion of budgetary resources obligated for undelivered orders as of September 30, 2025.

Note 19. 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	2025 Medicare	Other	Combined Funds from Dedicated Collections	Eliminations	Consolidated Funds from Dedicated Collections
Fund Balance with Treasury	$ 262,493	$ 21,359	$ 283,852	$ -	$ 283,852
Investments, Net	409,738	3,950	413,688	-	413,688
Accounts Receivable, Net	109,703	6,804	116,507	(115,860)	647
Advances and Prepayments	1	113	114	(76)	38
Total Intragovernmental Assets	**781,935**	**32,226**	**814,161**	**(115,936)**	**698,225**
Accounts Receivable, Net	31,756	9,267	41,023	-	41,023
Property, Plant and Equipment, Net	196	1,068	1,264	-	1,264
Advances and Prepayments	1	-	1	-	1
Other Assets	-	9	9	-	9
Total Other than Intragovernmental Assets	**31,953**	**10,344**	**42,297**	**-**	**42,297**
Total Assets	**$ 813,888**	**$ 42,570**	**$ 856,458**	**$ (115,936)**	**$ 740,522**
Accounts Payable	$ 120,066	$ 61	$ 120,127	$ (115,860)	$ 4,267
Debt	94	-	94	-	94
Advances from Others and Deferred Revenue	-	-	-	(76)	(76)
Other Liabilities	1	19	20	-	20
Total Intragovernmental Liabilities	**120,161**	**80**	**120,241**	**(115,936)**	**4,305**
Accounts Payable	143	300	443	-	443
Entitlement Benefits Due and Payable	104,695	-	104,695	-	104,695
Federal Employee Salary, Leave & Benefits Payable	12	147	159	-	159
Pensions and Post-Employment Benefits Payable	-	13	13	-	13
Advances from Others and Deferred Revenue	2,596	1,577	4,173	-	4,173
Other Liabilities	2,252	13,726	15,978	-	15,978
Total Other than Intragovernmental Liabilities	**109,698**	**15,763**	**125,461**	**-**	**125,461**
Total Liabilities	**$ 229,859**	**$ 15,843**	**$ 245,702**	**$ (115,936)**	**$ 129,766**
Unexpended Appropriations	233,517	3,386	236,903	-	236,903
Cumulative Results of Operations	350,512	23,341	373,853	-	373,853
Total Liabilities and Net Position	**$ 813,888**	**$ 42,570**	**$ 856,458**	**$ (115,936)**	**$ 740,522**
Statement of Net Cost					
Gross Program Costs	$ 1,151,455	$ 25,786	$ 1,177,241	$ 23	$ 1,177,264
Less: Earned Revenues	(160,942)	(20,480)	(181,422)	(41)	(181,463)
Net Cost of Operations	**$ 990,513**	**$ 5,306**	**$ 995,819**	**$ (18)**	**$ 995,801**
Statement of Changes in Net Position					
Unexpended Appropriations:					
Beginning Balance	$ 260,565	$ 3,351	$ 263,916	$ -	$ 263,916
Appropriations Received	657,683	251	657,934	-	657,934
Appropriation Used	(609,496)	(208)	(609,704)	-	(609,704)
Other	(75,235)	(8)	(75,243)	-	(75,243)
Total Unexpended Appropriations	**233,517**	**3,386**	**236,903**	**-**	**236,903**
Cumulative Results of Operations:					
Beginning Balance	326,649	21,400	348,049	-	348,049
Appropriations Used	609,496	208	609,704	-	609,704
Other than Intragovernmental Nonexchange Revenue:					
Nonexchange Revenue – Other	429	-	429	-	429
Intragovernmental Nonexchange Revenue	415,938	-	415,938	-	415,938
Donations and Forfeitures of Cash and Cash Equivalents	-	43	43	-	43
Transfers in/out without Reimbursement	(11,497)	5,673	(5,824)	-	(5,824)
Imputed Financing	10	1,308	1,318	(18)	1,300
Other	-	15	15	-	15
Net Cost of Operations	990,513	5,306	995,819	(18)	995,801
Net Change and Cumulative Results of Operations	23,863	1,941	25,804	-	25,804
Total Cumulative Results of Operations	**350,512**	**23,341**	**373,853**	**-**	**373,853**
Net Position, End of Period	**$ 584,029**	**$ 26,727**	**$ 610,756**	**$ -**	**$ 610,756**

Note 20. 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 health care 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 Sheet.

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to American Indians and Alaska Natives. 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.

Indian Trust Land	
IHS Area	**# of Sites**
Albuquerque	6
Bemidji	2
Billings	7
Great Plains	9
Navajo	36
Oklahoma City	1
Phoenix	10
Portland	3
Tucson	5
Total	**79**

Note 21. 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

	2025		
	Intragovernmental	Other than Intragovernmental	Total
Net Cost of Operations	**$ 10,354**	**$ 1,876,852**	**$ 1,887,206**
Components of Net Cost Not Part of the Outlays:			
Property, Plant, and Equipment Depreciation Expense	-	(971)	(971)
Lessee Lease Amortization	-	(29)	(29)
Cost of Goods Sold	-	(21)	(21)
Applied Overhead/Cost Capitalization Offset	-	547	547
Gains/Losses on All Other Investments	-	16	16
	-	**(458)**	**(458)**
Increase/(Decrease) in Assets:			
Accounts Receivable	(20)	10,649	10,629
Securities and Investments	442	-	442
Advances and Prepayments	(864)	72	(792)
Other Assets	-	(34)	(34)
	(442)	**10,687**	**10,245**
(Increase)/Decrease in Liabilities:			
Accounts Payable	440	189	629
Lease Liability	-	253	253
Debt	129	-	129
Entitlements Benefits Due and Payable	-	(22,355)	(22,355)
Federal Employee Salary, Leave and Benefits Payable	-	138	138
Pension and Post-Employment Benefits Payable	-	(1,438)	(1,438)
Accrued Liabilities	-	(871)	(871)
Contingencies and Commitments	-	(2,798)	(2,798)
Environmental and Disposal Liabilities	-	224	224
Other Liabilities	(50)	3,135	3,085
	519	**(23,523)**	**(23,004)**
Other Financing Sources:			
Imputed Financing	(2,496)	-	(2,496)
Total Components of Net Cost Not Part of the Outlays	**(2,419)**	**(13,294)**	**(15,713)**
Components of Outlays Not Part of Net Cost:			
Acquisition of Capital Assets	5	1,277	1,282
Acquisition of Inventory	1	2,818	2,819
Other Financing Sources:			
Donated Revenue	-	(42)	(42)
Transfers (in)/out without Reimbursement	1,559	-	1,559
Total Components of Outlays Not Part of Net Cost	**1,565**	**4,053**	**5,618**
Miscellaneous Items:			
Custodial/Non-Exchange Revenue	13,185	(526)	12,659
Non-entity activity	1,619	-	1,619
Appropriated Receipts for Trust/Special Funds	-	11,780	11,780
Reconciling Items:			
Debt	(129)	-	(129)
Custodial/Non-Exchange Revenue	(13,185)	526	(12,659)
Miscellaneous Receipts	(879)	-	(879)
Investment Interest Receivable	(442)	-	(442)
Unfunded Lease Liability	-	(228)	(228)
Other Expenses Not Requiring Budgetary Resources	-	(3,249)	(3,249)
Federal Share of Child Support Collections	(392)	-	(392)
Total Miscellaneous Items	**(223)**	**8,303**	**8,080**
Net Outlays	**$ 9,277**	**$ 1,875,914**	**$ 1,885,191**
Other Reconciling Items			(747)
Agency Outlays, Net			**$ 1,884,444**

Note 22. 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, 2025 (in Millions)						
FY 2025 HHS Statement of Net Cost		Line Items Used to Prepare FY 2025 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
		$ 1,174,006	**$ -**	**$ 886,709**	**$ 2,060,715**	***Non-Federal Costs***
						Intragovernmental Costs
		529	-	2,304	2,833	*Benefit Program Costs*
		1,318	(18)	1,196	2,496	*Imputed Costs*
		1,224	41	3,640	4,905	*Buy/Sell Costs*
		-	-	6	6	*Purchase of Assets*
		-	-	10	10	*Borrowing and Other Interest Expense*
		164	-	705	869	*Other Expenses (w/o Reciprocals)*
		$ 3,235	**$ 23**	**$ 7,861**	**$ 11,119**	**Total Intragovernmental Costs**
CMS: Gross Cost	$ 1,867,923					
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	203,909					
Total Gross Costs	**$ 2,071,832**	**$ 1,177,241**	**$ 23**	**$ 894,569**	**$ 2,071,833**	***Total Reclassified Gross Costs***
		$ (181,285)	**$ -**	**$ (2,913)**	**$ (184,198)**	**Non-Federal Earned Revenue**
						Intragovernmental Earned Revenue
		32	(41)	(749)	(758)	*Buy/Sell Revenue*
		-	-	(2)	(2)	*Borrowing and Other Interest Revenue*
		-	-	(6)	(6)	*Purchase of Assets Offset*
		$ 32	**$ (41)**	**$ (757)**	**$ (766)**	**Total Intragovernmental Earned Revenue**
CMS: Earned Revenue	$ (176,901)					
Other Segments: Earned Revenue	(8,221)					
Total Earned Revenue	**$ (185,122)**	**$ (181,253)**	**$ (41)**	**$ (3,669)**	**$ (184,963)**	***Total Reclassified Earned Revenue***
Actuarial (Gains) and Losses Commissioned Corps Retirement and Medical Plan Assumption Changes	496	-	-	497	497	Gain/Loss on Changes in Actuarial Assumptions (Non-Federal)
Net Cost of Operations	**$ 1,887,206**	**$ 995,988**	**$ (18)**	**$ 891,397**	**$ 1,887,366**	**Net Cost of Operations**

*Subtotals and totals may not equal due to rounding.

Notes to the Principal Financial Statements

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, 2025 (in Millions)			
FY 2025 HHS Statement of Change in Net Position		Line Items Used to Prepare FY 2025 Government-wide Statement of Changes in Net Position	
Financial Statement Line	Amounts	Total	Reclassified Financial Statement Line
UNEXPENDED APPROPRIATIONS			
Unexpended Appropriations, Beginning Balance	$ 583,911	$ 583,911	Unexpended Appropriations, Beginning Balance
Appropriations Received	1,590,792	1,590,792	Appropriations Received (RC 41)
Appropriations Transferred In/Out	(1,472)	18	Appropriations Transferred In/Out (RC 08)
Appropriations Used	(1,496,359)	(1,496,359)	Appropriations Used (RC 39)
Other Adjustments	(141,986)	(141,986)	Other Adjustments
Total Unexpended Appropriations	**$ 534,886**	**$ 536,376**	**Total Unexpended Appropriations**
CUMULATIVE RESULTS OF OPERATIONS			
Cumulative Results, Beginning Balance	$ 358,787	$ 358,783	Cumulative Results, Beginning Balance
Appropriations Used	1,496,359	1,496,359	Appropriations Expended (RC 38)
Nonexchange Revenue – Tax Revenue	400,622	400,622	Other Taxes and Receipts (RC 45)
Nonexchange Revenue – Investment Revenue	13,577	13,577	Federal Securities Interest Revenue, including Associated Gains/Losses (Non-Exchange) (RC 03)
		1,362	*Collections Transferred into a TAS Other Than the General Fund of the U.S. Government (RC 15)*
		2,927	*Other Taxes and Receipts (RC 45)*
		(934)	*Other Taxes and Receipts*
Nonexchange Revenue – Other	3,355	3,355	Total Other Taxes and Receipts
Donations and Forfeitures of Cash and Cash Equivalents	43	43	Other Taxes and Receipts
		998	*Expenditure Transfers in of Financing Sources (RC 09)*
		(4,025)	*Expenditure Transfers out of Financing Sources (RC 09)*
		(22)	*Non-expenditure Transfers in/out of Unexpended Appropriations and Financing Sources (RC 08)*
Transfers in/out Without Reimbursement – Budgetary	(1,559)	(3,049)	Total Transfers in/out without reimbursement
Donations and Forfeitures of Property	11	11	Donations and Forfeitures of Property
Imputed Financing	2,496	2,496	Imputed Financing Sources (RC 25)
		(3,184)	*Non-Entity Collections transferred to the General Fund (RC 44)*
		(102)	*Accrual for Non-Entity Amounts to be Collected and Transferred to the General Fund (RC 48)*
		1,818	*Other*
Other	(1,632)	(1,468)	Total Other
Total Financing Sources	**1,913,272**	**1,911,946**	**Total Financing Sources**
Net Cost of Operations	**1,887,206**	**1,887,366**	**Net Cost of Operations**
Ending Balance – Cumulative Results of Operations	**$ 384,853**	**$ 383,363**	**Total Cumulative Results of Operations**
Total Net Position	**$ 919,739**	**$ 919,739**	**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 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 2024 FR can be found at Fiscal Service's website (unaudited) and the 2025 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 are differences of $168 million due to exchange and non-exchange attribute difference between the HHS financial

reporting system and GTAS and $4 million due to custodial activities. The remainder of the differences are due to rounding.

Note 23. 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 *2025 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 health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. 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 [7] 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 occur if the Medicare HI trust fund became depleted. 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 Medicare 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 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 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,

[7]Because it was enacted after the release of the 2025 Medicare Trustees Report, the projections do not reflect the impact of the Medicare provisions in the *One Big Beautiful Bill Act* of 2025 (OBBBA: Public Law 119-21). Three provisions affect the Medicare program directly, with a negligible estimated impact on spending. The combined net effect of the income tax provisions in the OBBBA results in less overall tax liability for Social Security beneficiaries, meaning the HI trust fund is projected to receive less revenue from income taxation of Social Security benefits for all years beginning in 2025, and the timing for reserve depletion is accelerated by roughly one year. The 2026 Trustees Reports will reflect updated economic and demographic assumptions that incorporate the effects of the OBBBA as well as other factors and experience into the projections. As a result, the status of the HI trust fund that will be reported in the 2026 Medicare Trustees Report is uncertain at this time.

Similarly, the projections do not reflect the impact of the Medicare provisions in the *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026* (Public Law 119-37), which was enacted on November 12, 2025. The provisions included were temporary extensions of prior policies, a reduction in the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through February of 2033. The estimated impact is negligible over the next few years and there is no impact beyond 2033.

Lastly, the projections do not reflect the impact of the skin substitute policies finalized in the Calendar Year 2026 Physician Fee Schedule final rule, which was published on November 5, 2025. These policies significantly reduce spending for skin substitute services provided under Part B. Based on the projections reflected in the 2025 Medicare Trustees Report, the estimated impact on total Part B expenditures is a reduction of roughly 3.4 percent, including the reduction in fee-for-service spending and the associated impact on payments to Medicare Advantage plans, beginning in 2026.

legislation has delayed implementation three times, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The COVID-19 pandemic is no longer projected to have a significant impact on the Medicare program. Fee-for-service per capita spending has stabilized, and the Trustees rely more on recent experience when developing the cost projections. The only remaining adjustment is to account for the surviving population's morbidity improvement, which is expected to continue to affect spending levels through 2029.

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 health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI have 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 health care-specific assumptions, including changes in per beneficiary health care 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 health care 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 2025 SOSI actuarial projections are drawn from the Medicare Trustees Reports for 2025. 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).[8]

[8]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 2025

					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[13]
2025	1.64	2,102,000	764.4	1.47	3.97	2.47	2.3	3.7[9]	5.4[10,11]	5.9[11,12]	1.8
2030	1.72	1,323,000	734.3	1.45	3.88	2.40	2.0	4.6	7.2	2.2	1.7
2040	1.87	1,289,000	676.1	1.22	3.65	2.40	1.9	4.2	5.5	2.8	2.2
2050	1.90	1,260,000	623.8	1.08	3.51	2.40	1.8	3.3	3.7	4.0	2.3
2060	1.90	1,251,000	577.6	1.10	3.53	2.40	1.9	3.3	3.9	4.0	2.3
2070	1.90	1,244,000	536.6	1.13	3.56	2.40	1.8	3.4	3.6	3.8	2.3
2080	1.90	1,240,000	500.1	1.13	3.55	2.40	1.8	3.4	3.7	3.9	2.3
2090	1.90	1,237,000	467.6	1.13	3.56	2.40	1.9	3.6	3.8	4.0	2.3

[1]Average number of children per woman.

[2]Includes lawful permanent resident immigration, net of emigration, as well as temporary or unlawfully present 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 higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.

[10]Reflects higher projected spending for outpatient hospital and physician-administered drugs.

[11]Reflects *Inflation Reduction Act of 2022*.

[12]Reflects lower projected enrollment that is disproportionately lower for those eligible for low-income subsidies.

[13]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 2025-2021

					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]
2025	1.9	1,237,000	467.6	1.13	3.56	2.40	1.9	3.6	3.8	4.0	2.3
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

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2050.

[2]Includes lawful permanent resident (LPR) immigration, net of emigration, as well as temporary or unlawfully present immigration. The ultimate level of net LPR immigration is 788,000 persons per year, and the assumption for annual net temporary or unlawfully present immigration 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 24. 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. There remains continued uncertainty regarding adherence to current-law payment updates, particularly in the long range. This concern is more immediate for physician services, for which payment rate updates have been low or even negative for a number of years and are projected to be below the rate of inflation in all future years. Payment rate updates for most non-physician Medicare provider categories are reduced by the growth in economy-wide productivity 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.[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.

[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	$ 33,133	$ 33,218
Part B	68,530	76,922
Part D	10,733	10,732
Expenditures		
Part A	36,435	43,287
Part B	68,530	76,922
Part D	10,733	10,732
Income less expenditures		
Part A	(3,301)	(10,069)
Part B	-	-
Part D	-	-

[1]These amounts are not presented in the 2025 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 36 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 and the physician updates transitioned to the Medicare Economic Index, as illustrated under the alternative scenario, the estimated present values of Part A would be higher than the current-law projections by roughly 19 percent and Part B expenditures would be higher than the current-law projections by roughly 12 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 12 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 25. 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 non-interest 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, 2024 to the period beginning on January 1, 2025, and the reconciliation from the period beginning on January 1, 2023 to the period beginning on January 1, 2024. 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 health care 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 23 summarizes these assumptions for the current year.

Period beginning on January 1, 2024 and ending January 1, 2025

Present values as of January 1, 2024 are calculated using interest rates from the intermediate assumptions of the 2024 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2025. 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 2024 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 health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2025 Trustees Report.

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 health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2024 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2024 to the period beginning on January 1, 2025

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2024-98) to the current valuation period (2025-99) 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 2024, replaces it with a much larger negative net cash flow for 2099, and measures the present values as of January 1, 2025, 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 2024-98 to 2025-99. 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 2024 are realized. The change in valuation period resulted in a small increase 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 $75 billion.

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.

Change in Projection Base

From the period beginning on January 1, 2024 to the period beginning on January 1, 2025

Actual income and expenditures in 2024 were different from what was anticipated when the 2024 Trustees Report projections were prepared. For Part A, B, and D 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 a decrease of $638 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, 2024 and January 1, 2025 is incorporated in the current valuation and is less than projected in the prior valuation.

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.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2024 to the period beginning on January 1, 2025

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

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2025) 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. The most significant changes are identified below.

- The ultimate total fertility rate of 1.9 children per woman is reached in 2050, which is 10 years later than assumed in the prior valuation.
- Final birth rate data for calendar year 2023 and preliminary data for 2024 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.
- Assumed levels of temporary or unlawfully present immigrant entrants in the period 2022–25 are higher than under the prior valuation.
- Mortality data, historical population data, immigration data, marriage data, and divorce data were updated since the prior valuation.

There were two notable changes in demographic methodology.

- The method used for projecting death rates now incorporates Medicare data for deaths at ages 95 through 99, rather than using data only for ages up to 94 as in the prior valuation.
- The method used for projecting temporary or unlawfully present immigration was improved to better reflect recent data on the composition of the entrant population by age.

These changes resulted in an increase in the estimated future net cash flow. For Part A, Part B and Part D, the present value of estimated expenditures and income are lower. Overall, these changes increased the present value of the estimated future net cash flow by $275 billion.

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 OASDI and are prepared by the Office of the Chief Actuary at the SSA.

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

- The ultimate total fertility rate was lowered from 2.0 children per woman to 1.9 children per woman, and at the same time, the year the ultimate total fertility rate 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, temporary or unlawfully present 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.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2024 to the period beginning on January 1, 2025

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, 2025), there was one change to the ultimate economic assumptions. The ratio of total labor compensation to GDP is assumed to increase gradually to 61.2 percent in 2034, and to remain approximately constant thereafter. In the prior valuation, this ratio was assumed to be about 62.8 percent for 2033 and later. This assumption change, considered by itself, implies somewhat slower average earnings growth over the first ten projection years and a level shift in average earnings in the longer term.

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 one significant change is that historical OASDI covered employment for 2022 was slightly higher and its age distribution was different than assumed under the prior valuation.

Additionally, there were several notable changes in economic methodology.

- The model to project the civilian non-institutional (CNI) population was updated to make the CNI projections more consistent with the projections of the Social Security area population.

- The method used for projecting average weeks worked during a calendar year, a key component of projections of OASDI covered employment, was updated. The updated approach uses historical data through 2021 and a more directly relevant data source.
- The process used to calculate and apply adjustments that smooth the age profile of labor force participation rates was improved, resulting in a decrease in projected labor force participation rates of workers age 75 and older relative to the prior valuation.

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

- Higher Part A projected spending growth because of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services.
- Higher Part B projected spending growth due to higher projected spending for outpatient hospital and physician-administered drugs.
- Lower Part D projected spending growth because of lower Part D enrollment which is disproportionately lower for those eligible for low-income subsidies.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A, these changes decreased the present value of estimated future income and increased 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 expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $236 billion.

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 health care 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 expenditures (and income). Overall, these changes increased the present value of the estimated future net cash flow by $2,106 billion.

Changes in Law

For the period beginning on January 1, 2024 to the period beginning on January 1, 2025

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 Consolidated Appropriations Act, 2024 (Public Law 118-42, enacted on March 9, 2024) 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 November 30, 2032. (In other words, the benefit payment reductions for the month of November 2032 are changed from 0 percent to 2 percent.)
- The funding amount of $2,197,795,056 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-35 in last year's report, is reduced to $0. (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.)
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through December 31, 2024 (from September 30, 2024). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After December 31, 2024, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after September 30, 2024, is extended through December 31, 2024. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)
- 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 December 31, 2024 (from March 8, 2024).
- In the formula used for determining payment rates under the physician fee schedule, the physician payment update is changed for services furnished March 9, 2024, through December 31, 2024. As a result, the update of −1.22 percent, which was to be in effect throughout 2024, is now to apply only through March 8, and an update of 0.42 percent (as compared with the 2023 payment level) is to apply for the remainder of the year.
- For physicians participating in advanced alternative payment models, incentive payment availability is extended 1 year, through performance year 2024. However, for payment year 2026 (which applies to performance year 2024), the incentive payments are to equal 1.88 percent of fee schedule payments (as compared with 5 percent for 2019–2024 and 3.5 percent for 2025). In addition, the current freeze on the

participation thresholds that must be met to qualify for the incentive payments is extended for the same additional year. (The more stringent thresholds will now first apply in 2027.)

The Continuing Appropriations and Extensions Act, 2025 (Public Law 118-83, enacted on September 26, 2024) included provisions that affect the HI and SMI programs.

- The funding amount of $0 that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2022, as discussed under Public Law 118-42, is increased to $3,197 million for services furnished during and after FY 2026.
- 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; that is, the next data-reporting period is now the first quarter of 2026 (instead of the first quarter of 2025). 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 2021–2025 (rather than 2021–2024) are to be paid at the same rates as under the 2020 fee schedule, and payments for tests provided during 2026–2028 (rather than 2025–2027) may not be reduced by more than 15 percent per year.

The American Relief Act, 2025 (Public Law 118-158, enacted on December 21, 2024) included provisions that affect the HI and SMI programs.

- The funding amount of $3,197 million that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2026, as discussed under Public Law 118-83, is decreased to $1,251 million.
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through March 31, 2025 (from December 31, 2024). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After March 31, 2025, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after December 31, 2024, is extended through March 31, 2025. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)
- 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 March 31, 2025 (from December 31, 2024).
- Certain ground ambulance add-on payments that had been extended through December 31, 2024, under previous legislation are now extended through March 31, 2025. 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.

The Full-Year Continuing Appropriations and Extensions Act, 2025 (Public Law 119-4, enacted on March 15, 2025) 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 2 months, through January 31, 2033. (In other words, the benefit payment reductions for the months of December 2032 and January 2033 are changed from 0 percent to 2 percent.)
- The funding amount of $1,251 million that was previously provided to the Medicare Improvement Fund for services furnished during and after FY 2026, as discussed under Public Law 118-158, is increased to $1,804 million.
- For hospitals to qualify for low-volume add-on payments, the most recent criteria are extended through September 30, 2025 (from March 31, 2025). Specifically, hospitals must have fewer than 3,800 total discharges annually and be located 15 road miles or more from another acute care hospital. The most recent sliding scale used to determine the add-on percentages is also extended. After September 30, 2025, the qualifying criteria and sliding scale will revert to their original parameters if this provision is not further extended.
- The Medicare-Dependent Hospital (MDH) program, which was scheduled to expire after March 31, 2025, is extended through September 30, 2025. (In addition, in most cases, MDH hospitals that had requested reclassification as sole community hospitals may decline this reclassification and reinstate their MDH status.)
- 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 September 30, 2025 (from March 31, 2025).
- Certain ground ambulance add-on payments that had been extended through March 31, 2025, under Public Law 118-158 are now extended through September 30, 2025. 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.

These changes resulted in a slight decrease in the Part A present values of estimated expenditures and a small increase in the Part B present value of estimated expenditures (and income). For Part D, there was no change in the present values of estimated expenditures (and income). Overall, these changes increased the present value of the estimated future net cash flow by $2 billion for total Medicare.

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.

Required Supplementary Information

Combining Statement of Budgetary Resources

For the Year Ended September 30, 2025
(in Millions)

	CMS					
	Medicare HI	Medicare SMI	Payments to Trust Funds	Medicaid	Other Agency Accounts	Agency Combined Totals
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 1,870	$ 1,394	$ 219,774	$ 50,232	$ 114,486	$ 387,756
Appropriations (Discretionary and Mandatory)	444,127	579,608	630,204	665,739	376,240	2,695,918
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	1,861	44,210	46,071
Total Budgetary Resources	**$ 445,997**	**$ 581,002**	**$ 849,978**	**$ 717,832**	**$ 534,936**	**$ 3,129,745**
New Obligations and Upward Adjustments	$ 445,997	$ 581,002	$ 629,955	$ 717,809	$ 419,600	$ 2,794,363
Unobligated Balance, End of Year:						
Apportioned, Unexpired Accounts	-	-	244	5	66,983	67,232
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	1,234	1,234
Unapportioned, Unexpired Accounts	-	-	5	18	18,374	18,397
Unexpired Unobligated Balance, End of Year	-	-	249	23	86,591	86,863
Expired Unobligated Balance, End of Year	-	-	219,774	-	28,745	248,519
Unobligated Balance, End of Year	-	-	220,023	23	115,336	335,382
Total Status of Budgetary Resources	**$ 445,997**	**$ 581,002**	**$ 849,978**	**$ 717,832**	**$ 534,936**	**$ 3,129,745**
Outlays, Net (Discretionary and Mandatory)	$ 444,833	$ 578,553	$ 592,024	$ 661,745	$ 394,219	$ 2,671,374
Distributed Offsetting Receipts	(57,178)	(727,170)	-	-	(2,582)	(786,930)
Agency Outlays, Net (Discretionary and Mandatory)	**$ 387,655**	**$ (148,617)**	**$ 592,024**	**$ 661,745**	**$ 391,637**	**$ 1,884,444**
Disbursements, Net	**$ -**	**$ -**	**$ -**	**$ -**	**$ (134)**	**$ (134)**

Required Supplementary Information

Summary of Other Agency Accounts

	Budgetary Resources	Outlays, Net
ACF	$ 85,649	$ 75,267
ACL	2,743	3,015
AHRQ	398	367
ASPR	4,289	1,966
CDC	23,263	17,800
CMS	294,244	199,667
FDA	9,285	3,206
HRSA	14,825	15,072
IHS	18,167	8,334
NIH	59,326	47,182
OS	10,752	10,857
PSC	2,581	568
SAMHSA	9,414	8,336
Totals	**$ 534,936**	**$ 391,637**

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 in the Automated Real Property Inventory Reporting System (ARIS) database.

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.

Required Supplementary Information

In ARIS, mission-critical facilities are marked as 3-High. The minimum maintenance and repair amount needed to ensure mission critical facilities remain mission capable is $0.4 billion.

Estimated Cost to Return to Acceptable Condition

(in Millions)

Category of Asset	2025 Beginning Balance	2025 Ending Balance
PP&E		
Buildings	$ 4,919	$ 5,291
Other Structures	34	36
Total	**$ 4,953**	**$ 5,327**

Required Supplementary Information

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 Division and total estimated acreage.

Estimated Acreage by Predominant* Use

	Operational				
	CDC	FDA	IHS	NIH	Total Estimated Acreage
PP&E Land					
Start of Year	941	730	2,354	1,312	5,337
End of Year	973	734	2,466	1,312	5,485
Stewardship Land					
Start of Year	-	-	1,115	-	1,115
End of Year	-	-	1,115	-	1,115
Held for Disposal or Exchange					
Start of Year	-	-	6	-	6
End of 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	2025
Albuquerque	17
Bemidji	23
Billings	118
Great Plains	185
Navajo	703
Oklahoma City	6
Phoenix	30
Portland	3
Tucson	30
Total	**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 six decades. A brief description of the provisions of Medicare's Federal Hospital Insurance (HI, or Part A) trust fund and Federal 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 *2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

With two exceptions, the projections are based on the current-law provisions [10] of the *Social Security Act*. The first exception is that the Part A projections disregard payment reductions that would occur if the Medicare HI trust fund became depleted. 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 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, legislation has delayed implementation three times, and it is currently delayed until January 1, 2032. Therefore, the likelihood of this rule taking effect is highly uncertain.

The COVID-19 pandemic is no longer projected to have a significant impact on the Medicare program. Fee-for-service per capita spending has stabilized, and the Trustees rely more on recent experience when developing the cost projections. The only remaining adjustment is to account for the surviving population's morbidity improvement, which is expected to continue to affect spending levels through 2029.

Certain features of current law may result in some challenges for the Medicare program. This concern is more immediate for physician services, for which payment rate updates have been low or even negative for a number of years and are projected to be below the rate of inflation in all future years. Payment rate updates for most non-physician Medicare provider categories are reduced by the growth in economy-wide private nonfarm business total

[10]Because it was enacted after the release of the 2025 Medicare Trustees Report, the projections do not reflect the impact of the Medicare provisions in the *One Big Beautiful Bill Act* of 2025 (OBBBA; Public Law 119-21). Three provisions affect the Medicare program directly, with a negligible estimated impact on spending. The combined net effect of the income tax provisions in the OBBBA results in less overall tax liability for Social Security beneficiaries, meaning the HI trust fund is projected to receive less revenue from income taxation of Social Security benefits for all years beginning in 2025, and the timing for reserve depletion is accelerated by roughly one year. The 2026 Trustees Report will reflect updated economic and demographic assumptions that incorporate the effects of the OBBBA as well as other factors and experience into the projections. As a result, the status of the HI trust fund that will be reported in the 2026 Medicare Trustees Report is uncertain at this time.

Similarly, the projections do not reflect the impact of the Medicare provisions in the *Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026* (Public Law 119-37) which was enacted on November 12, 2025. The provisions included were temporary extensions of prior policies, a reduction in the Medicare Improvement Fund, and a 1-month extension of the sequestration of Medicare benefits through February of 2033. The estimated impact is negligible over the next few years and there is no impact beyond 2033.

Lastly, the projections do not reflect the impact of the skin substitute policies finalized in the Calendar Year 2026 Physician Fee Schedule final rule, which was published on November 5, 2025. These policies significantly reduce spending for skin substitute services provided under Part B. Based on the projections reflected in the 2025 Medicare Trustees Report, the estimated impact on total Part B expenditures is a reduction of roughly 3.4 percent, including the reduction in fee-for-service spending and the associated impact on payments to Medicare Advantage plans, beginning in 2026.

factor productivity.[11] However, 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);
- *National Defense Authorization Act for Fiscal Year 2024* (Public Law 118-31, enacted on December 22, 2023);
- *Consolidated Appropriations Act, 2024* (Public Law 118-42, enacted on March 9, 2024); and
- *Full-Year Continuing Appropriations and Extensions Act, 2025* (Public Law 119-4, enacted on March 15, 2025).

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 January 31, 2033.

Because of sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013, through January 31, 2033, 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 health care provider categories, 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

[11]The term economy-wide private nonfarm business total factor productivity will now 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.

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.

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 health care 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 the following:

- There would be a transition from current-law [12] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; and
- The average physician payment updates would transition from current law [13] to payment updates that reflect the Medicare Economic Index.

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 24 in these consolidated 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 (unaudited). [14]

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. [15] 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. [16]

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

[12]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 in economy-wide productivity (1.0 percent over the long range).

[13]The law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced alternative payment models or the merit-based incentive payment system, 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.

[14]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.

[15]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.

[16]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)).

increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, 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 health care 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 health care 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 3.6 percent in 2049, or GDP plus 0.0 percent, declining gradually to 3.4 percent in 2099, or GDP minus 0.3 percent.

(ii) *Physician services.*

Payment rate updates are 0.75 percent per year for qualified physicians assumed to be participating in advanced alternative payment models and 0.25 percent for those assumed to be participating in the merit-based incentive payment system. The year-by-year cost growth rates for physician payments are assumed to decline from 3.1 percent in 2049, or GDP minus 0.5 percent, to 2.8 percent in 2099, or GDP minus 0.9 percent.

(iii) *Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in economy-wide productivity.*

Such services include durable medical equipment that is not subject to competitive bidding,[17] care at ambulatory surgical centers, ambulance services, and medical supplies.

The year-by-year cost growth rates for these services are assumed to decline from 2.8 percent in 2049, or GDP minus 0.8 percent, to 2.6 percent in 2099, 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.*

Payments for these Part B services are established through market processes and are not affected by the productivity adjustments. For physician-administered Part B drugs, the *Inflation Reduction Act*'s key inflation provisions are not anticipated to affect such payments over the long range.

[17]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 2025 Trustees Report.

The long-range cost growth rates for these services are assumed to equal the growth rates as determined from the "factors contributing to growth" model. The corresponding year-by-year cost growth rates decline from 4.3 percent in 2049, or GDP plus 0.7 percent, to 4.1 percent by 2099, or GDP plus 0.4 percent.

(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 this law 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. 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 this legislation, that such trends would continue over the long range.

The *Inflation Reduction Act* is expected to change this dynamic because it requires the change in prices (before rebate adjustments) to be limited to the rate of growth in the CPI. The inflation provisions would likely lower price trends, though it is anticipated that they would outpace the CPI because of 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 slightly more slowly over the long range than would be the case if they were determined strictly through market processes.

The corresponding year-by-year cost growth rates decline from 4.1 percent in 2049, or GDP plus 0.5 percent, to 3.9 percent by 2099, or GDP plus 0.2 percent.

These long-range cost growth rates must be modified to account for 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 adjustment. This adjustment reflects the fact that the closer an individual is to death, the higher his or her health care 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 health care is offset somewhat.[18] 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 time-to-death 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 2049,[19] or GDP plus 0.3 percent, declining to 3.8 percent by 2099, or GDP plus 0.1 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 3.8 percent, or GDP plus 0.2 percent in 2049, declining to 3.7 percent, or GDP plus 0.0 percent by 2099.

HI Cash Flow as a Percentage of Taxable Payroll

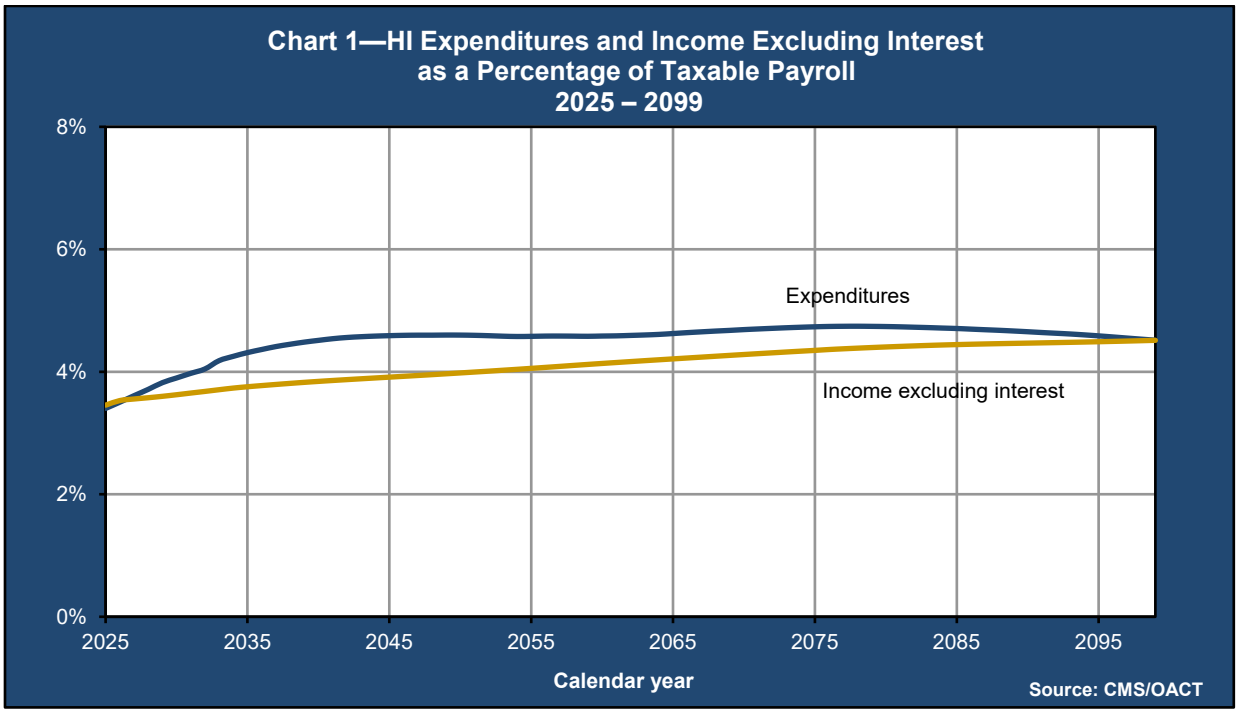
Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore,

[18]More information on the time-to-death adjustment is available on the CMS website (unaudited).

[19]In 2049, the shares of Part B spending are 28 percent for services updated by input price indexes, 16 percent for physician services, 6 percent for services updated by the CPI, and 51 percent for the remaining Part B services.

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 higher than those from last year for all years because of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services. These impacts are partially offset by lower payment updates.



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. High-income workers also 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 the income tax brackets are indexed to the chained CPI, 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 chained CPI 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 taxable payroll. [20] Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

[20]For more detailed information on the projection of income from taxation of Social Security benefits, see Section V.C7 of the *2025 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.*

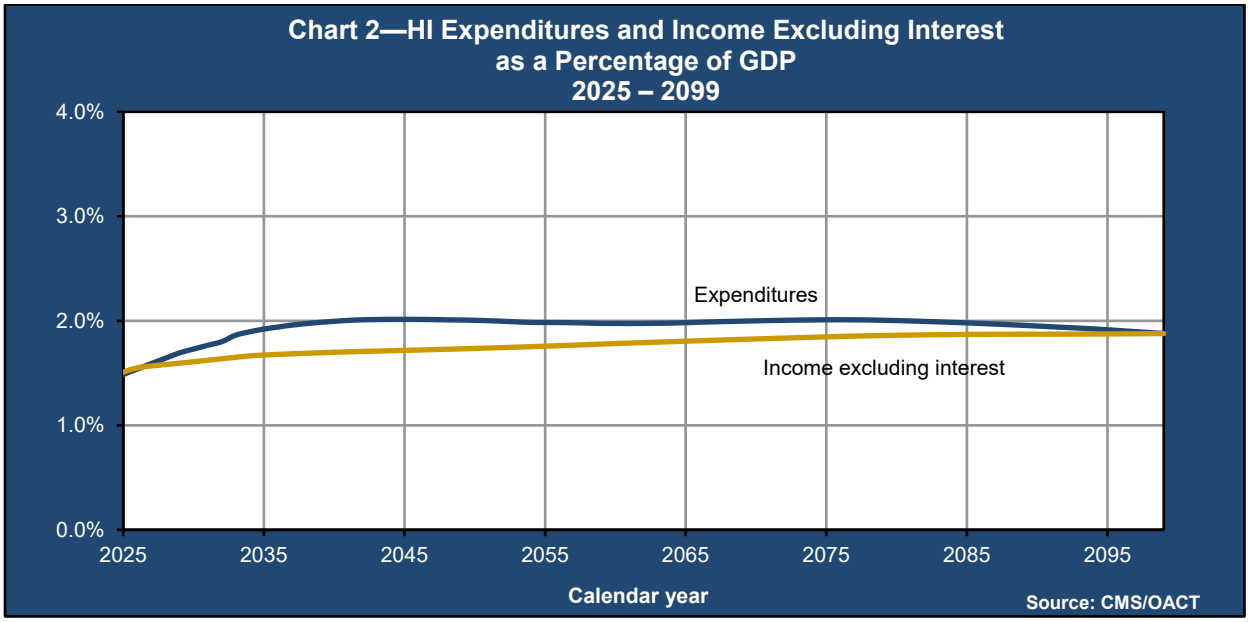
After remaining steady in 2023 and 2024, as indicated in Chart 1, the cost rate is projected to rise in 2025 and beyond primarily as a result of an acceleration of health services cost growth. This cost rate increase is moderated by the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.8 percent through 2034 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.0 percent in 2050 and 6.9 percent in 2099.

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 with 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 2024, the expenditures were $422.5 billion, which was 1.4 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 2099.

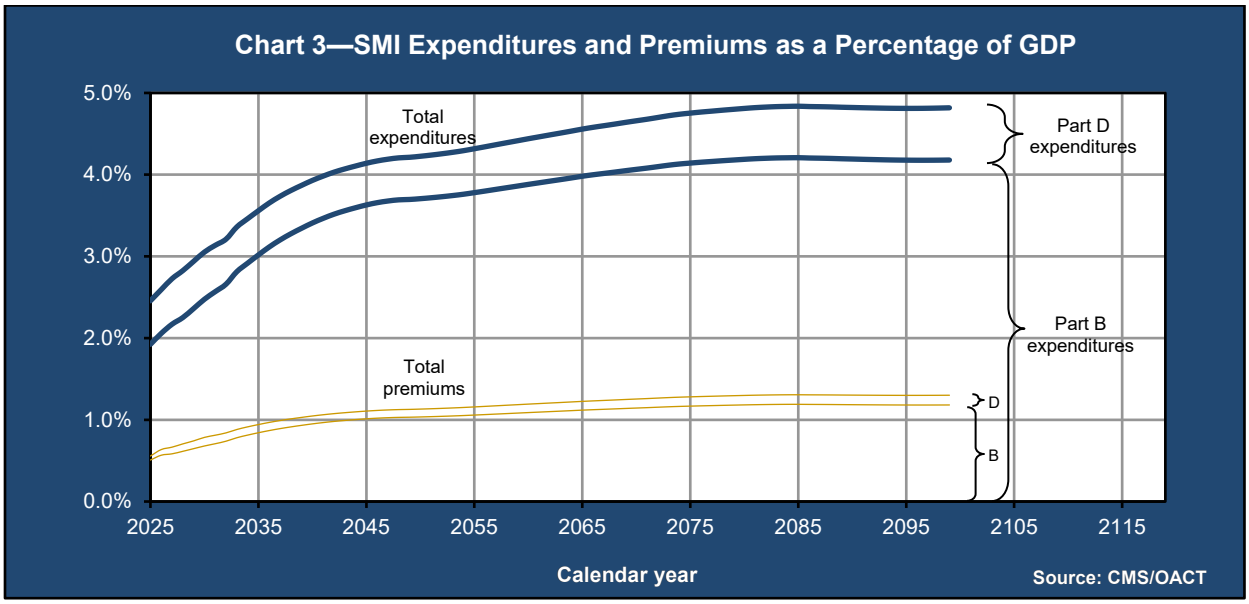


SMI

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.

Required Supplementary Information

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.



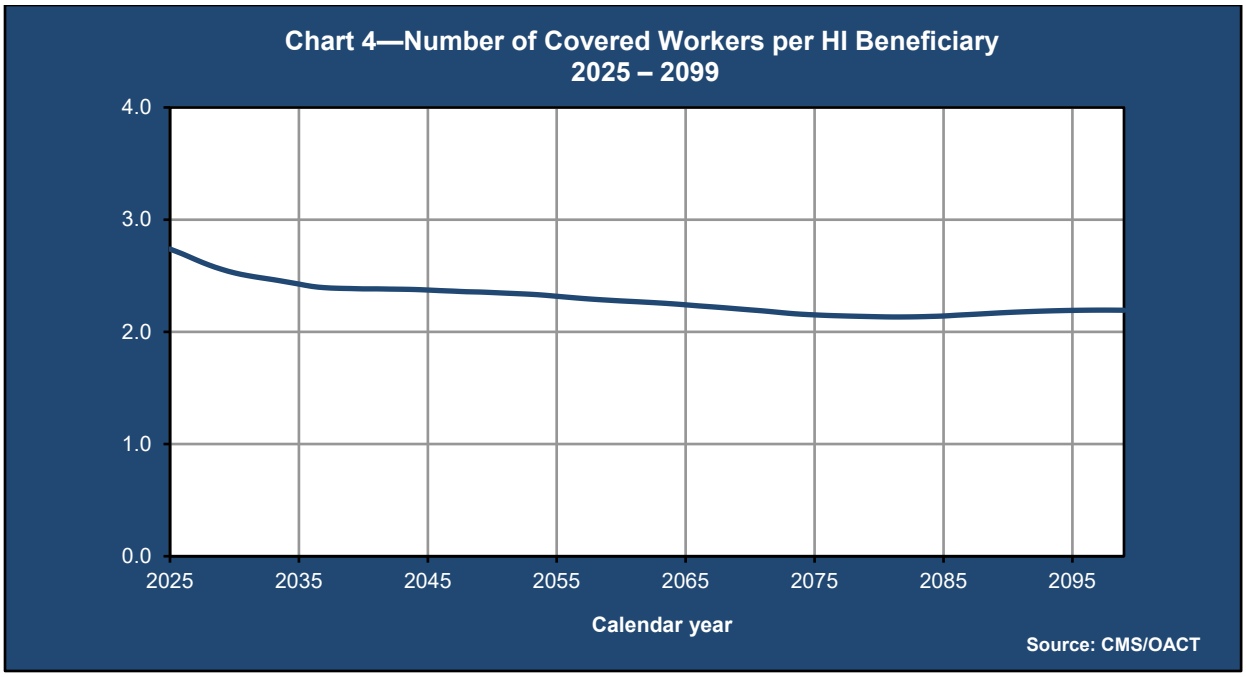
In 2024, SMI expenditures were $699.6 billion, or about 2.4 percent of GDP. Under current law, they would grow to about 4.2 percent of GDP within 25 years and to 4.8 percent by the end of the projection period, as demonstrated in Chart 3. Under the illustrative alternative, total SMI expenditures in 2099 would be 5.9 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 with the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2024 by about 4.3 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 2024, 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 2.2 workers per beneficiary by 2099.

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, resulting from either changed conditions or updated information, estimates sometimes change substantially compared with 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.[21] The assumptions varied are the health care cost factors, real-wage growth, CPI, real-interest rate, fertility rate, and net immigration.[22]

For this analysis, the intermediate economic and demographic assumptions in the 2025 Trustees Report were used as the reference point. Each selected assumption was varied individually to produce three scenarios. All present values were calculated as of January 1, 2025, and are based on estimates of income and expenditures during the 75-year projection period.

[21]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.

[22]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.

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.

Health Care Cost Factors

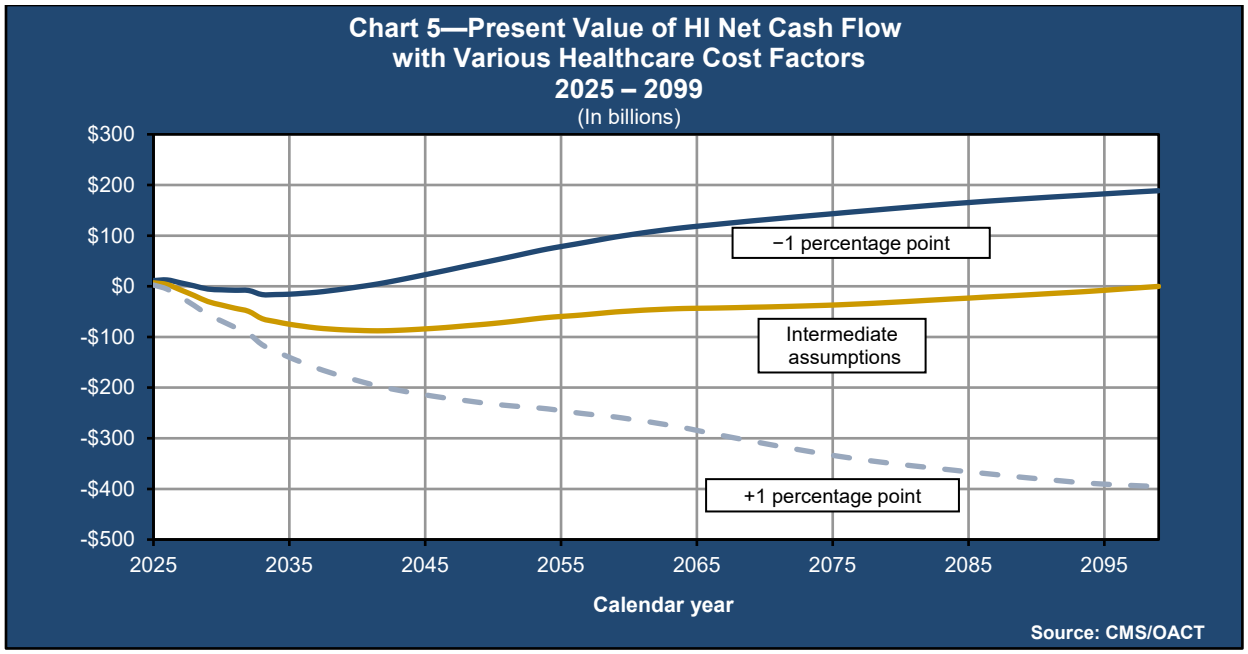
Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs,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

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	−1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$6,916	−$3,301	−$19,623

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $10,217 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 $16,322 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.



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 health care 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, 1.13, and 1.73 percentage points.[23] 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

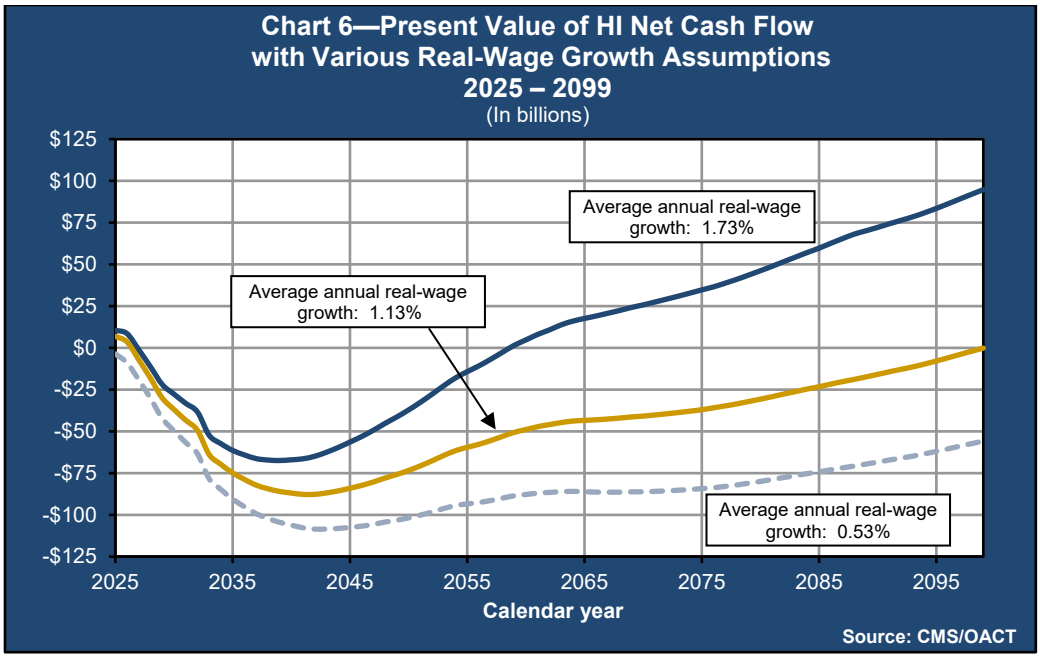
Ultimate percentage increase in real-wage growth	0.53	1.13	1.73
Income minus expenditures (in billions)	−$6,021	−$3,301	$622

As indicated in Table 2, for each 0.6-percentage-point increase in the ultimate real-wage growth assumption, the deficit—expressed in present-value dollars—decreases, on average, by about $3,321 billion.

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.

[23]Real-wage growth is the annual percentage change in average covered wages adjusted for the average percentage change in the CPI.

Required Supplementary Information



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 health care 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 health care 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

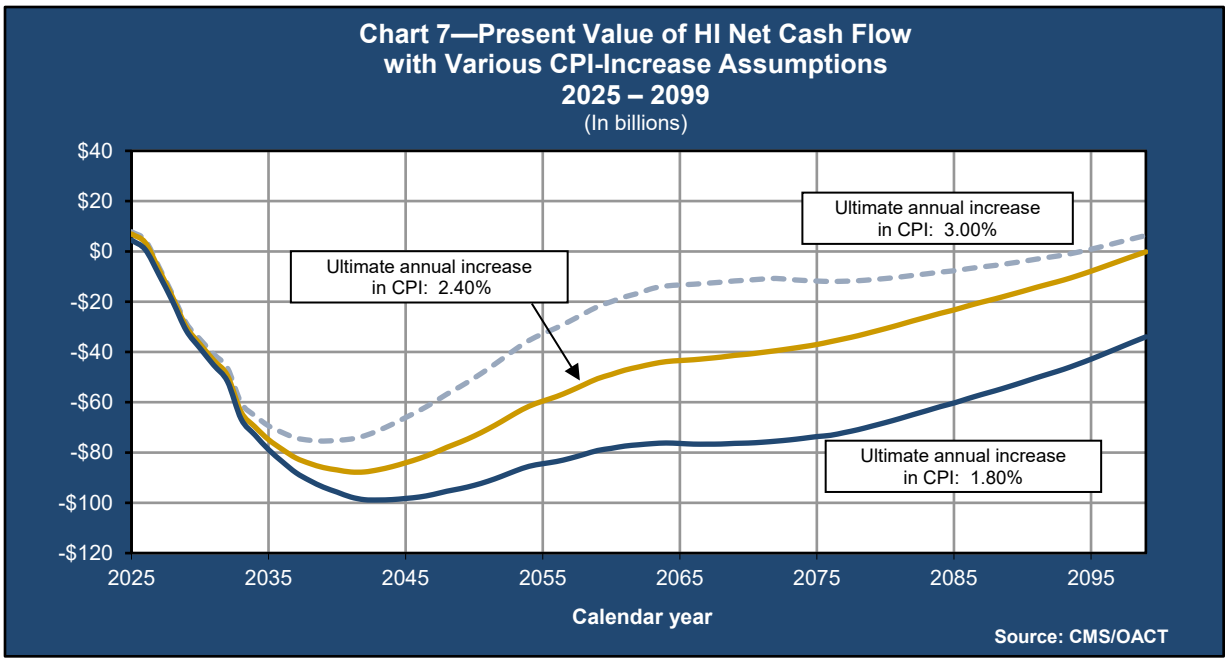
Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the ultimate real-wage growth assumption is 1.13 percent.

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)	−$2,001	−$3,301	−$5,144

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,300 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by approximately $1,842 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

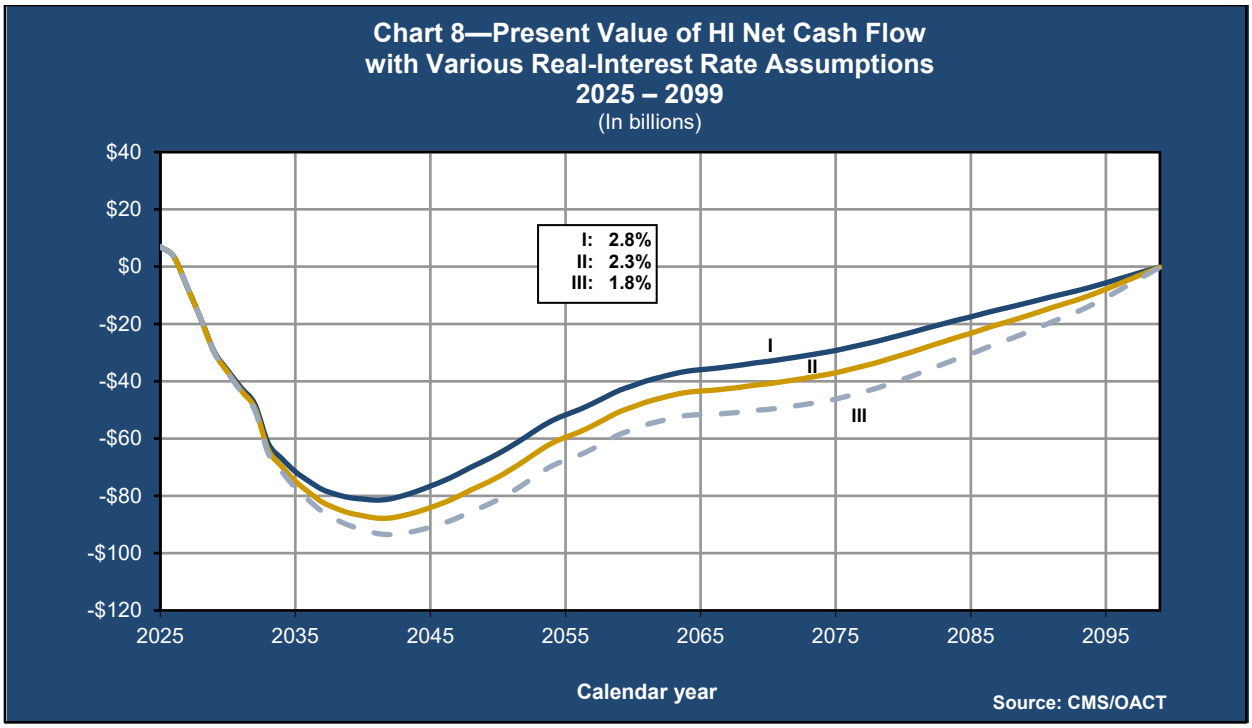
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 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)	-$3,744	-$3,301	-$2,887

As demonstrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $85 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 2033. 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

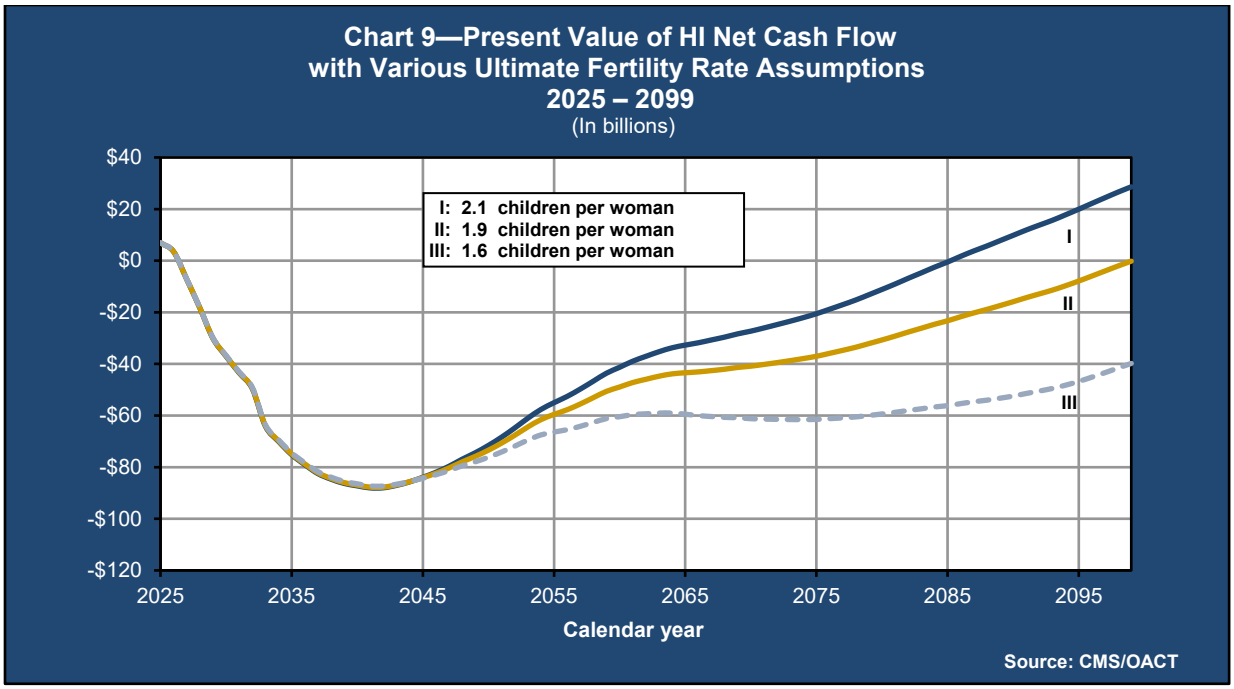
Ultimate fertility rate[1]	1.6	1.9	2.1
Income minus expenditures (in billions)	−$4,471	−$3,301	−$2,494

[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 $395 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.

Required Supplementary Information



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

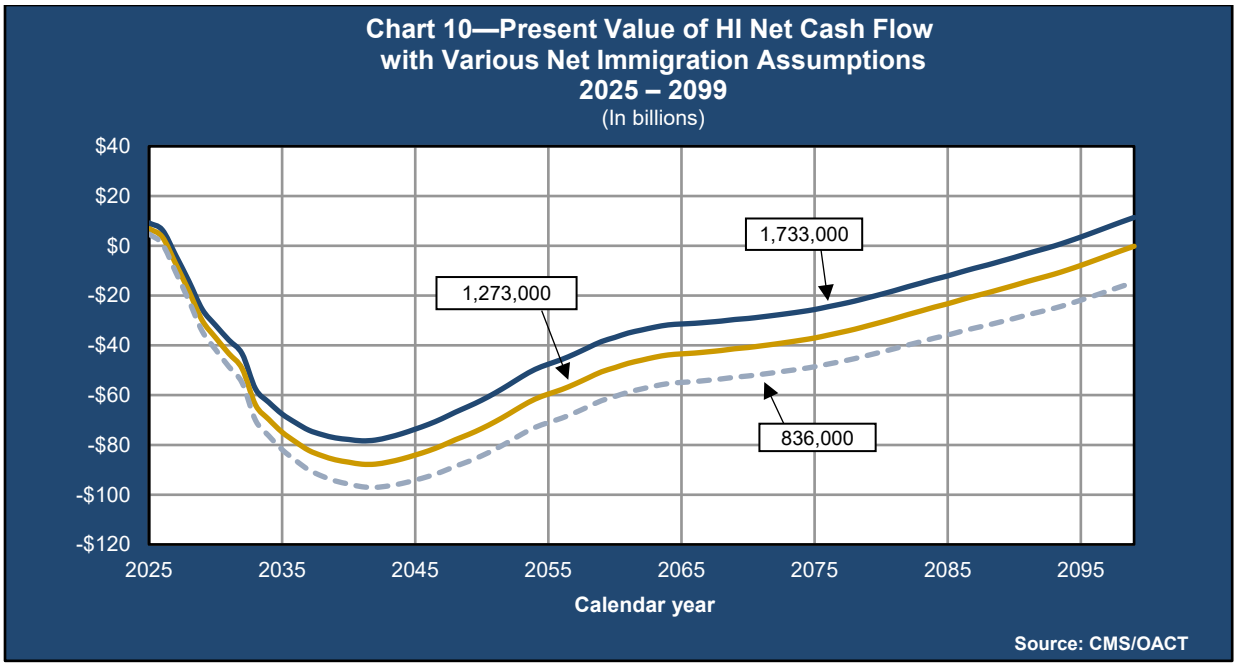
Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 836,000 persons, 1,273,000 persons, and 1,733,000 persons per year.

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

Average annual net immigration	836,000	1,273,000	1,733,000
Income minus expenditures (in billions)	−$4,093	−$3,301	−$2,533

As indicated in Table 6, if the average annual net immigration assumption is 836,000 persons, the deficit—expressed in present-value dollars—increases by $792 billion. Conversely, if the assumption is 1,733,000 persons, the deficit decreases by approximately $769 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

This year's short-range financial outlook for the HI trust fund is less favorable than last year's Medicare Trustees Report projections. The estimated depletion date for the HI trust fund is 2033, 3 years earlier than projected in last year's Trustees Report. HI income is projected to be initially higher and then lower throughout the projection period because average wages are initially higher and then lower. HI expenditures are projected to be higher through the short-range period mainly as a result of higher-than-anticipated 2024 expenditures and higher projected spending for inpatient hospital and hospice services. These impacts are partially offset by lower payment updates.

HI expenditures exceeded income each year from 2008 through 2015. However, in 2016 and 2017, 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. In 2023 and 2024 there were surpluses of $12.2 billion and $28.7 billion, respectively.

The Trustees project that surpluses will continue through 2027, followed by deficits until the trust fund becomes depleted in 2033. 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 health care services could be rapidly reduced. To date, Congress has never allowed the HI trust fund to become depleted.

Required Supplementary Information

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 long-term financial integrity of HI 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 imbalance.

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. However, this financing 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 expenditures and dedicated financing sources [24] will exceed 45 percent of total Medicare expenditures within the next 7 fiscal years (2025–2031). For the 2025 Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2025. The Trustees are therefore issuing a determination. [25]

Because this determination was made last year as well, this year's determination results in a Medicare funding warning, which requires the following:

- The President to submit to Congress proposed legislation to respond to the warning within 15 days after the Fiscal Year 2027 Budget submission; and
- 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 2024 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 HI trust fund's projected depletion, 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 2025 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 quickly address these challenges."

[24] 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.
[25] Section V.B of the 2025 Trustees Report contains additional details on these tests.

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SECTION 3 OTHER INFORMATION

- OTHER FINANCIAL INFORMATION
- SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES
- GRANTS CLOSEOUT REPORTING
- PAYMENT INTEGRITY REPORT
- FY 2025 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY THE OFFICE OF INSPECTOR GENERAL
- DEPARTMENT'S RESPONSE TO THE OFFICE OF INSPECTOR GENERAL

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Other Financial Information

Consolidating Balance Sheet by Budget Function

As of September 30, 2025

(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)	$ 17,333	$ 335,263	$ 262,493	$ 44,262	$ 659,351	$ -	$ 659,351
Investments, Net (Note 4)	-	4,585	409,738	-	414,323	-	414,323
Accounts Receivable, Net (Note 5)	434	10,711	109,703	-	120,848	(120,085)	763
Advances and Prepayments (Note 8)	141	1,928	1	402	2,472	(506)	1,966
Total Intragovernmental Assets	**17,908**	**352,487**	**781,935**	**44,664**	**1,196,994**	**(120,591)**	**1,076,403**
Other than Intragovernmental Assets							
Accounts Receivable, Net (Note 5)	-	17,434	31,756	22	49,212	-	49,212
Inventory and Related Property, Net (Note 6)	-	19,183	-	-	19,183	-	19,183
Property, Plant and Equipment, Net (Note 7)	2	9,193	196	-	9,391	-	9,391
Advances and Prepayments (Note 8)	-	99	1	18	118	-	118
Other Assets	-	386	-	-	386	-	386
Total Other than Intragovernmental Assets	**2**	**46,295**	**31,953**	**40**	**78,290**	**-**	**78,290**
Total Assets	**$ 17,910**	**$ 398,782**	**$ 813,888**	**$ 44,704**	**$ 1,275,284**	**$ (120,591)**	**$ 1,154,693**
Stewardship Land (Note 20)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 10	$ 1,081	$ 120,066	$ 2	$ 121,159	$ (120,060)	$ 1,099
Debt	-	358	94	-	452	-	452
Advances from Others and Deferred Revenue	-	1,005	-	1	1,006	(506)	500
Other Liabilities (Note 13)	2	1,728	1	14	1,745	(25)	1,720
Total Intragovernmental Liabilities	**12**	**4,172**	**120,161**	**17**	**124,362**	**(120,591)**	**3,771**
Other than Intragovernmental Liabilities							
Accounts Payable	13	1,287	143	-	1,443	-	1,443
Entitlement Benefits Due and Payable (Note 10)	-	59,257	104,695	-	163,952	-	163,952
Federal Employee Salary, Leave and Benefits Payable (Note 11)	17	1,331	12	14	1,374	-	1,374
Pensions and Post-Employment Benefits Payable (Note 11)	3	22,564	-	-	22,567	-	22,567
Environmental and Disposal Liabilities	-	229	-	-	229	-	229
Advances from Others and Deferred Revenue	-	1,769	2,596	-	4,365	-	4,365
Other Liabilities:							
Accrued Liabilities (Note 12)	860	16,388	-	794	18,042	-	18,042
Contingencies and Commitments (Note 14)	-	15,535	2,250	-	17,785	-	17,785
Other Liabilities (Note 13)	-	1,411	2	13	1,426	-	1,426
Total Other than Intragovernmental Liabilities	**893**	**119,771**	**109,698**	**821**	**231,183**	**-**	**231,183**
Total Liabilities	**905**	**123,943**	**229,859**	**838**	**355,545**	**(120,591)**	**234,954**
Net Position							
Unexpended Appropriations – Funds from Dedicated Collections (Note 19)	-	3,386	233,517	-	236,903	-	236,903
Unexpended Appropriations – Funds from Other Than Dedicated Collections	16,870	237,349	-	43,764	297,983	-	297,983
Total Unexpended Appropriations	**16,870**	**240,735**	**233,517**	**43,764**	**534,886**	**-**	**534,886**
Cumulative Results of Operations – Funds from Dedicated Collections (Note 19)	-	23,341	350,512	-	373,853	-	373,853
Cumulative Results of Operations – Funds from Other Than Dedicated Collections	135	10,763	-	102	11,000	-	11,000
Total Cumulative Results of Operations	**135**	**34,104**	**350,512**	**102**	**384,853**	**-**	**384,853**
Total Net Position	**17,005**	**274,839**	**584,029**	**43,866**	**919,739**	**-**	**919,739**
Total Liabilities and Net Position	**$ 17,910**	**$ 398,782**	**$ 813,888**	**$ 44,704**	**$ 1,275,284**	**$ (120,591)**	**$ 1,154,693**

Other Financial Information

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2025
(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	$ 17,620	$ -	$ -	$ 58,721	$ 76,341	$ (269)	$ 13	$ 76,085
ACL	3,067	-	-	-	3,067	(15)	2	3,054
AHRQ	-	352	-	-	352	(23)	14	343
ASPR	-	1,081	-	-	1,081	(51)	2	1,032
CDC	-	17,853	-	-	17,853	(281)	126	17,698
CMS	-	700,713	990,513	-	1,691,226	(215)	11	1,691,022
FDA	-	3,801	-	-	3,801	(346)	12	3,467
HRSA	-	14,964	-	-	14,964	(129)	7	14,842
IHS	-	8,389	-	-	8,389	(262)	13	8,140
NIH	-	47,124	-	-	47,124	(259)	886	47,751
OS	-	12,944	-	-	12,944	(860)	327	12,411
PSC	-	2,216	-	-	2,216	(90)	955	3,081
SAMHSA	-	8,287	-	-	8,287	(86)	79	8,280
Totals	**$ 20,687**	**$ 817,724**	**$ 990,513**	**$ 58,721**	**$ 1,887,645**	**$ (2,886)**	**$ 2,447**	**$ 1,887,206**

Gross Cost and Earned Revenue

For the Year Ended September 30, 2025
(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	$ 1,238	$ (269)	$ 969	$ (24)	$ 13	$ (11)	$ 75,151	$ (24)	$ 76,085
ACL	43	(15)	28	(3)	2	(1)	3,029	(2)	3,054
AHRQ	40	(23)	17	(16)	14	(2)	334	(6)	343
ASPR	225	(51)	174	(43)	2	(41)	899	-	1,032
CDC	1,413	(281)	1,132	(232)	126	(106)	16,768	(96)	17,698
CMS	2,368	(215)	2,153	(23)	11	(12)	1,865,770	(176,889)	1,691,022
FDA	1,999	(346)	1,653	(27)	12	(15)	5,292	(3,463)	3,467
HRSA	300	(129)	171	(8)	7	(1)	14,741	(69)	14,842
IHS	1,230	(262)	968	(87)	13	(74)	9,956	(2,710)	8,140
NIH	2,431	(259)	2,172	(976)	886	(90)	46,758	(1,089)	47,751
OS	2,078	(860)	1,218	(447)	327	(120)	11,326	(13)	12,411
PSC	481	(90)	391	(1,205)	955	(250)	2,942	(2)	3,081
SAMHSA	153	(86)	67	(115)	79	(36)	8,249	-	8,280
Totals	**$ 13,999**	**$ (2,886)**	**$ 11,113**	**$ (3,206)**	**$ 2,447**	**$ (759)**	**$ 2,061,215**	**$ (184,363)**	**$ 1,887,206**

Other Financial Information

Federal Entity Trading Partner Information

For the Year Ended September 30, 2025
(in Millions)

Reciprocal Category (RC)	Nature of Transactions	Balance	Federal Trading Partner
General Fund	Appropriations Used/Expended (RC 39/38)	$ 1,496,359	General Fund
	Appropriations received as adjusted (rescissions and other adjustments) (RC 41)	1,448,806	
	Fund Balance with Treasury (RC 40)	659,351	
	Other taxes and receipts (RC 45)	403,549	
	Non-entity collections transferred to the General Fund of the U.S. Government (RC 44)	3,184	
Investments	Federal investments (RC 01)	$ 411,315	Treasury
	Federal securities interest revenue including associated gains and losses (non-exchange) (RC 03)	13,577	
	Interest receivable – investments (RC 02)	3,008	
Buy/Sell	Buy/sell cost (RC 24)	$ 4,905	DOI GSA
	Advances and prepayments (RC 23)	1,966	DOI
	Other liabilities – Reimbursable activities (RC 22)	1,226	Treasury
Transfers	Expenditure transfers-out of financing sources (RC 09)	$ 4,025	SSA
Benefits	Benefit program costs (RC 26)	2,833	OPM
Imputed Costs	Imputed financing sources/costs (RC 25)	$ 2,496	OPM Treasury
Custodial	Collections transferred into a TAS Other Than the General Fund of the U.S. Government – Nonexchange (RC 15)	$ 1,362	DOJ

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 Six Financial Statements 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*, July 14, 2025, page 106)

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.

Summary of Financial Statement Audit and Management Assurances

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 Weakness 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/ Non-Compliances	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
Payment Integrity Information Act of 2019 (PIIA)*	1	1	0	-	-	2
Total Material Weaknesses/ Noncompliances	*1*	*1*	*0*	-	-	*2*

* HHS identified material noncompliance with PIIA due to (a) not reporting an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program, and (b) not reporting an improper payment estimate below the statutory 10 percent threshold for the Head Start program (new noncompliance).

Conformance with Federal Financial Management System Requirements (FMFIA Section 4)

Statement of Assurance	Federal Systems Conform to Financial Management System Requirements					
Non-Conformances	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Reassessed**	**Ending Balance**
None	0	-	-	-	-	0
Total Non-Conformances	*0*	-	-	-	-	*0*

Summary of Financial Statement Audit and Management Assurances

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

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 2022 – 2023	3-5 Years FYs 2020 – 2022	More than 5 Years Before FY 2020
Number of Grants/Cooperative Agreements with Zero Dollar Balances	1,526	638	91
Number of Grants/Cooperative Agreements with Undisbursed Balances	1,631	1,313	596
Total Amount of Undisbursed Balances	**$2,034,374,789.05**	**$1,559,892,582.86**	**$384,127,210.27**

HHS continues to make grant closeouts a priority by reengineering 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 5,795 grant awards with a POP end date of September 30, 2023, or earlier that are expired but not yet closed.

HHS remains committed to addressing and remediating complexities that prevent the closeout of open but expired accounts. The remaining backlog is primarily due to expired amounts permitted under appropriations law and statutory authority, including COVID-19 awards with extended liquidation periods. In FY 2026, HHS will continue its work in optimizing the grants closeout process through a comprehensive reengineering initiative. Enhanced technology infrastructure will support timely actions and more efficient grant closeouts. Additionally, systems have been actively engaged in streamlining business processes tailored to their unique workflows to facilitate better data sharing across platforms.

Payment Integrity Report

OVERVIEW

HHS estimates, reports, and works to reduce improper payments—payments that do not meet legal requirements or are made in incorrect amounts—and unknown payments, which lack documentation to confirm the payment is proper. These efforts are conducted in compliance 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). All risk-susceptible programs—except Temporary Assistance for Needy Families (TANF), which does not calculate and report an improper payment estimate due to statutory limitations—complied with OMB sampling and estimation guidance and reported improper payment estimates. The Advance Premium Tax Credit (APTC) program's estimate does not yet include payments from State-based Exchanges. Additional information on agency and program-specific improper payment results and corrective actions is available at PaymentAccuracy.gov.

RISK-SUSCEPTIBLE PROGRAMS

Risk-susceptible programs are programs identified as vulnerable to significant improper or unknown payments. A program is considered risk-susceptible if its improper and unknown payments exceed the statutory thresholds for significant improper payments:

1) 1.5 percent of program outlays and $10,000,000 in a fiscal year, or
2) $100,000,000 in improper and unknown payments, regardless of the percentage.

High-priority programs are those with reported monetary loss of $100,000,000 or more in a reporting year. Under OMB guidance, these programs require additional quarterly reporting. HHS distinguishes between reporting year (RY) and fiscal year (FY) in this report because improper payment measurements reported in RY 2025 may not align with payments made in FY 2025. Measurement methodologies vary by program and may include payments under review from prior fiscal years.

The following programs are risk-susceptible and require annual improper payment measurement and reporting; programs designated as high-priority for calendar year (CY) 2025 are marked with an asterisk (*):

- Medicare Fee-for-Service (Parts A and B)*
- Medicare Advantage (Part C)*
- Medicare Prescription Drug Benefit (Part D)*
- Medicaid*
- Children's Health Insurance Program (CHIP)
- Advance Premium Tax Credit (APTC)*
- Temporary Assistance for Needy Families (TANF)
- Foster Care
- Child Care and Development Fund (CCDF)
- Head Start*

PAYMENT CATEGORIES

HHS estimates and reports proper payments (payments meeting legal requirements), improper payments (payments made in incorrect amounts or to ineligible recipients), and unknown payments (lacking sufficient documentation to determine the payment is proper). Improper payments are further categorized into:

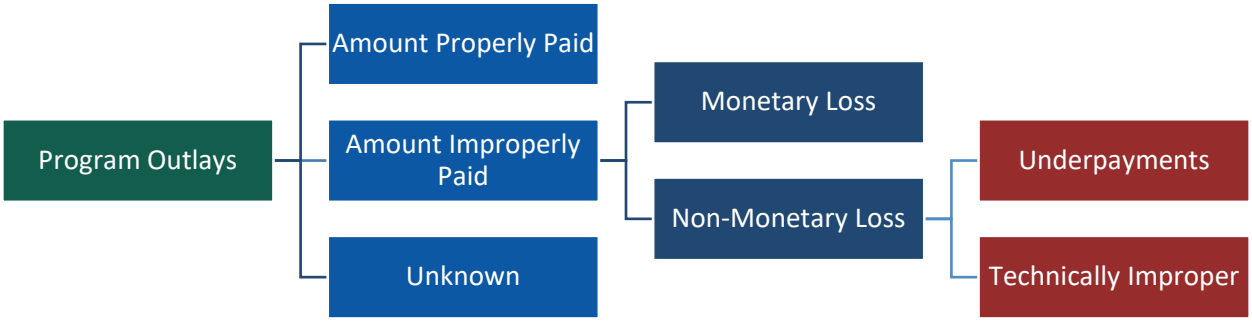
- **Monetary loss**: Overpayments that should not have been made.
- **Non-monetary loss**: Underpayments or technically improper payments (correct amounts but process or compliance deficiencies).

Improper payment estimates are not fraud estimates; while all fraud payments are monetary loss improper payments, not all monetary loss improper payments result from fraud.

Common root causes of improper payments include insufficient documentation from providers or states to support payment in accordance with program requirements, administrative errors, and eligibility determination issues. These insights guide corrective actions to reduce future improper payments and compliance errors.

Figure 1 illustrates payment categories and types of improper payments.

Figure 1: Payment Categories



IMPROPER PAYMENT RISK ASSESSMENTS, ESTIMATION, AND REPORTING

HHS conducts risk assessments of all programs with annual outlays exceeding $10 million to determine susceptibility to significant improper payments. Programs likely to have improper and unknown payments above statutory thresholds are required to report annual improper payment estimates. Programs likely to remain below thresholds must complete risk assessments at least once every three years. HHS conducted 97 risk assessments in FY 2025 and found no programs at risk of significant improper payments.

PROPER, IMPROPER, AND UNKNOWN PAYMENTS FOR RISK-SUSCEPTIBLE PROGRAMS

HHS estimated improper and unknown payments for each risk-susceptible program. **Figure 2** illustrates the estimated proper, improper, and unknown payments. **Figure 3** illustrates the overpayments, underpayments, and technically improper payment estimates for all of HHS's risk-susceptible programs. **Table 1** summarizes FY 2025 proper, improper, and unknown payments. Agency and program-specific improper payment results are available on PaymentAccuracy.gov.

HHS estimated 5.89% percent improper payments in all risk-susceptible programs, totaling $98.34 billion in FY 2025. The majority stemmed from insufficient documentation, state eligibility verification errors (including those

conducted as part of redeterminations), and provider screening and enrollment errors. Corrective actions target these root causes through better training, data sharing, and automated checks.

Figure 2: RY 2025 HHS Payments: Estimated Proper, Improper, and Unknown (Dollar Amounts in Billions)

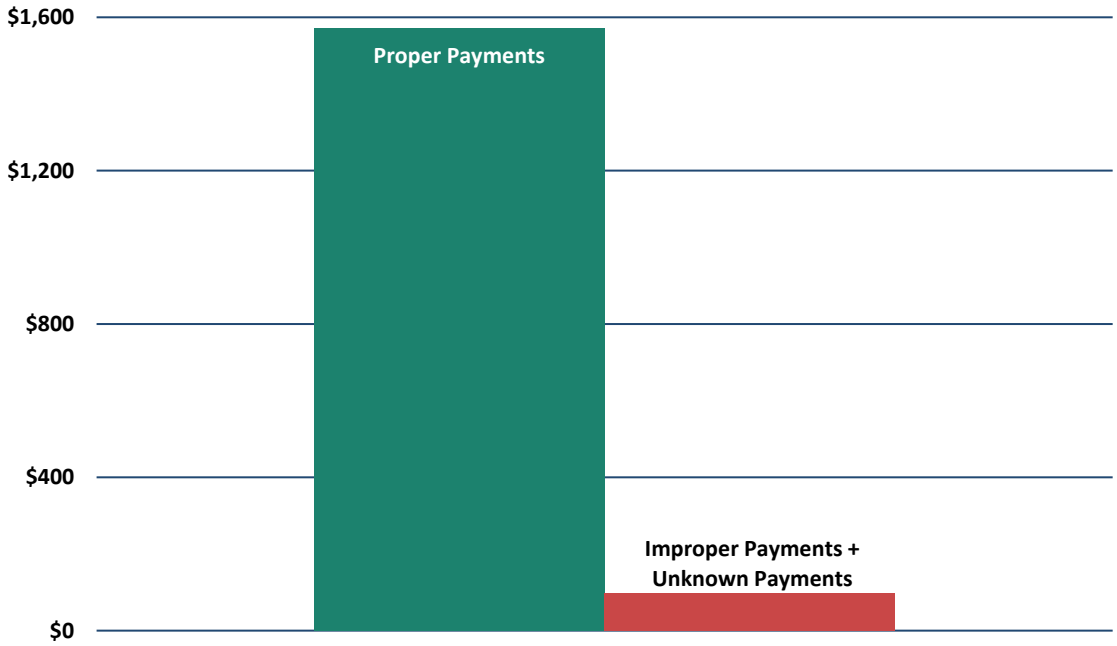


Figure 3: Breakdown of RY 2025 HHS Estimated Improper Payments

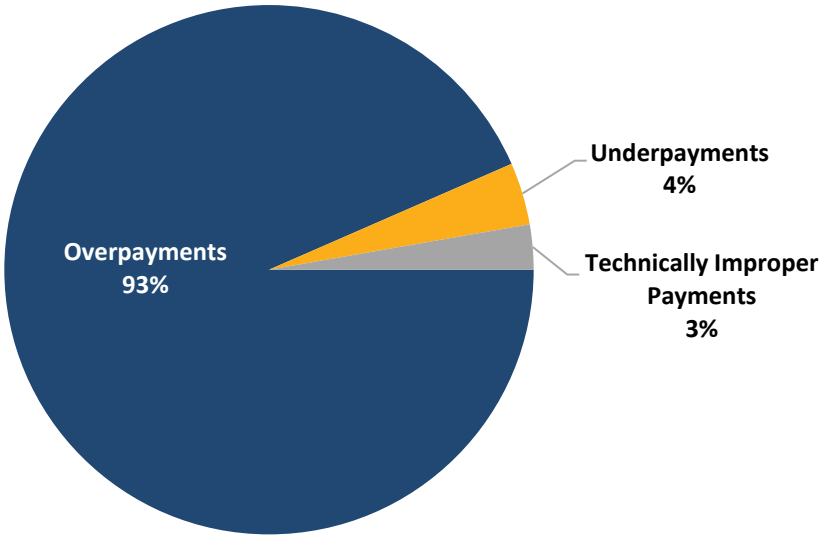


Table 1: HHS's Risk-Susceptible Programs' Improper Payment Results

RY 2025 (in Millions)[1]

Program or Activity	RY Outlays $	RY PP %	RY IP + UP $[2]	RY IP + UP %[2]	RY+1 Reduction Target %[3]
Medicare FFS [a]	$439,878.69 [b]	93.45%	$28,826.59	6.55% [c]	6.45%
Medicare Part C	$388,716.84 [d]	93.91%	$23,665.12	6.09%	6.43% [e]
Medicare Part D	$105,559.08 [f]	96.00%	$4,225.80	4.00%	4.23% [g]
Medicaid [h]	$610,988.02 [i]	93.88%	$37,386.79	6.12% [j]	8.99% [k]
CHIP [h]	$19,448.78 [l]	92.95%	$1,371.71	7.05% [m]	9.52% [k]
APTC	$73,812.75 [n]	99.11%	$657.46	0.89 % [o]	N/A [p]
TANF	$16,543.60 [q]	N/A	N/A	N/A [r]	N/A
Foster Care	$1,295.00 [s]	94.28%	$74.07	5.72%	N/A [t]
CCDF [h]	$18,698.59 [u]	95.07%	$921.46	4.93%	4.67%
Head Start	$11,726.70 [v]	89.71%	$1,206.87	10.29%	9.87%

[1] Totals do not necessarily equal the sum of the rounded components.

[2] The only program with unknown payments is Head Start. An improper payment determination could not be made at the time of this report due to limitations in verifying transaction-level data.

[3] Although publishing reduction targets is required, these targets apply to payment years that have already occurred. As a result, any corrective actions developed in response to improper payment estimates may not affect the estimates for several years.

ACCOMPANYING NOTES FOR TABLE 1: HHS'S RISK-SUSCEPTIBLE AND HIGH-PRIORITY PROGRAMS' IMPROPER PAYMENT RESULTS AND OUTLOOK

a) Medicare FFS includes Part A and Part B. The Railroad Retirement Board (RRB) administers Medicare Part B benefits for railroad retirees.

b) Medicare FFS RY outlays are from the FY 2025 Medicare FFS Improper Payments Report (based on claims submitted from July 2023 – June 2024).

c) 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 0.2 percentage points to 6.55 percent or $28.83 billion. Additional adjustment factor information is on pages 166-167 of HHS's FY 2012 AFR.

d) Medicare Part C RY 2025 outlays reflect 2023 Part C payments, as reported in the FY 2025 Medicare Part C Payment Error Final Report available at the Medicare Part C Improper Payment Measurement website.

e) HHS expects the RY 2026 Medicare Part C rate to be statistically similar to the RY 2025 rate; however, HHS will continue to observe how the rate fluctuates when setting RY+1 targets. For 2026 RY, HHS established a relationship mid-way between the upper limit of the 95 percent confidence interval and the current year improper payment estimate to provide a realistic outyear target.

f) Medicare Part D RY 2025 outlays reflect 2023 Part D payments, as reported in the FY 2025 Medicare Part D Payment Error Final Report available at the Medicare Part D Improper Payment Measurement website.

g) HHS expects the RY 2026 Medicare Part D rate to be statistically similar to the RY 2025 rate; however, HHS will continue to observe how the rate fluctuates when setting RY+1 targets. For RY 2026, HHS established a relationship mid-way between the upper limit of the 95 percent confidence interval and the current year improper payment estimate to provide a realistic outyear target.

h) For Medicaid, CHIP, Foster Care, and CCDF, estimates are derived from rolling three-year samples that incorporate a portion of states' data annually.

i) Medicaid RY outlays are based on FY 2024 expenditures (Medicaid – Outlays current law exclude Centers for Disease Control and Prevention (CDC) Vaccine for Children program funding).

j) HHS calculated and is reporting the national Medicaid estimates based on measurements conducted in RYs 2023, 2024, and 2025. The national Medicaid component improper payment estimates are Medicaid FFS: 4.60 percent, Medicaid Managed Care: 0.00 percent, and Medicaid Eligibility: 4.42 percent.

k) 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 after the end of the public health emergency. The target assumes an increase similar to what was measured this year in improper payments due to the unwinding of flexibilities that were afforded during the public health emergency and a partial improvement based on observable reduction in improper payments outside those related to unwinding.

l) CHIP RY outlays are based on FY 2024 expenditures.

m) HHS calculated and is reporting the national CHIP estimates based on measurements conducted in RYs 2023, 2024, and 2025. The national CHIP component improper estimates are CHIP FFS: 4.65 percent, CHIP Managed Care: 0.94 percent, and CHIP Eligibility: 5.23 percent.

n) APTC RY outlays are for the Federally-facilitated Exchange only and are based on benefit year 2023 (January 1, 2023 to December 31, 2023).

o) The APTC improper payment results represent improper payments for the Federally-facilitated Exchange. HHS continues to develop the improper payment measurement methodology for the State-based Exchanges, which represents 19.93 percent of total APTC payments, and will continue to update the AFR with the measurement program development status.

p) 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.

q) TANF RY 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).

r) The TANF program is not reporting estimates for RY 2025. Statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement.

s) Foster Care RY outlays are based on the *FY 2025 President's Budget* baseline and reflect the federal share of maintenance payments.

t) HHS resumed conducting Title IV-E reviews in 2024. The RY 2025 estimate is based on review data from 26 states or territories operating traditional Title IV-E programs. Twenty states were newly added to the estimate this year and six states were reviewed in RY 2024. HHS is not reporting a RY+1 reduction target and will not do so until all states have been newly reviewed and the program reestablishes a baseline.

u) CCDF RY outlays are based on the *FY 2025 President's Budget* baseline.

v) Head Start RY outlays are based on the *FY 2025 President's Budget* baseline.

Table 2: Amounts Improperly Paid by Program[1]

RY 2025 (in Millions)

	Monetary Loss		Non-Monetary Loss		
Program or Activity	Overpayments	Percent of Total Payments	Underpayments	Technically Improper	Percent of Total Payments
Medicare FFS	$27,869.70	**6.34%**	$956.88	$0.00	**0.22%**
Medicare Part C	$21,434.34	**5.51%**	$2,230.78	$0.00	**0.57%**
Medicare Part D	$3,703.19	**3.51%**	$522.61	$0.00	**0.50%**
Medicaid	$35,029.54	**5.73%**	$256.75	$2,100.50	**0.39%**
CHIP	$1,304.78	**6.71%**	$5.73	$61.21	**0.34%**
APTC	$375.02	**0.51%**	$0.00	$282.44	**0.38%**
Foster Care	$66.30	**5.12%**	$7.77	$0.00	**0.60%**
CCDF	$845.47	**4.52%**	$75.99	$0.00	**0.41%**
Head Start	$2.69	**0.02%**	$5.47	$188.38	**1.65%**
Total [2]	**$90,631.03**	**5.43%**	**$4,061.98**	**$2,632.53**	**0.40%**

[1] Unknown payments are not included in Table 2. See Figure 1: Payment Categories. An improper payment determination could not be made at the time of this report due to limitations in verifying transaction-level data, including missing or insufficient documentation to determine if the payment was proper.

[2] Totals do not necessarily equal the sum of the rounded components.

MITIGATION STRATEGIES & CORRECTIVE ACTIONS

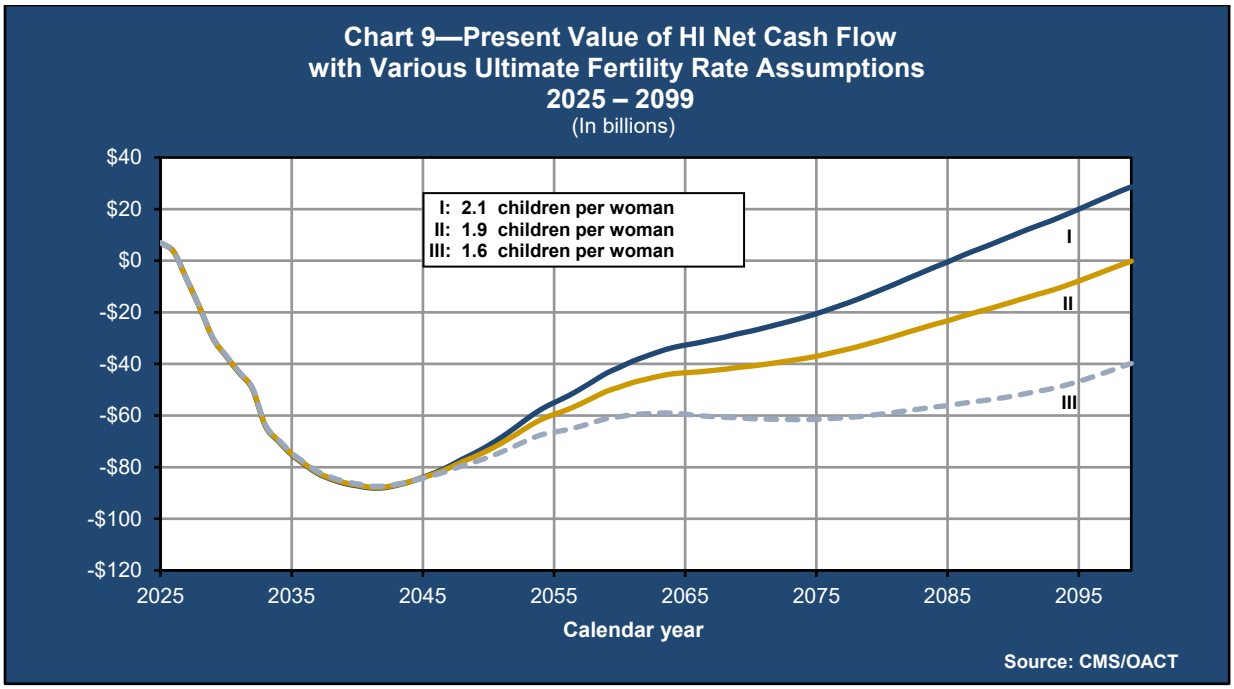
HHS programs with significant improper payments have set reduction targets and implemented corrective actions to address root causes. Efforts include both cross-cutting strategies that strengthen payment integrity across programs and program-specific actions tailored to unique risks. For detailed information regarding HHS's actions to reduce improper payments, see www.cms.gov/fraud.

HHS identified improper payments resulting from factors both within and outside of the agency's control. HHS addresses the root causes of improper payments within its authority by strengthening oversight of disbursements. Alternatively, when factors outside the agency's control contribute to improper payments, HHS provides training and technical assistance to state partners, providers, prescription drug plans, and grantees to reduce risks. Because improper payment estimates reflect different payment years, the impact of corrective actions may not appear until the current payment year is measured and reported.

Cross-Cutting Mitigation Strategies

- **Strengthened eligibility verification:** Expanded use of federal data sources (e.g., Death Master File) and enhanced checks during enrollment and redeterminations.
- **Provider screening and oversight:** Increased use of the Do Not Pay system, more rigorous provider enrollment reviews, and contract audits.
- **Enhanced Pre-Payment Processes:** HHS is upgrading its payment systems to use Do Not Pay, enabling identification and resolution of ineligible or improper payments before submission to Treasury. Once complete, all programs and recurring payments will undergo Do Not Pay pre-certification checks.
- **Public Assistance Reporting Information System (PARIS):** Provides state public assistance agencies in all 50 states, the District of Columbia, and Puerto Rico with data-matching capabilities to verify program eligibility and deter improper payments in TANF, Medicaid, Workers' Compensation, child care programs, and Supplemental Nutrition Assistance Program with cross-state data-matching.

Required Supplementary Information



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: 836,000 persons, 1,273,000 persons, and 1,733,000 persons per year.

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

Average annual net immigration	836,000	1,273,000	1,733,000
Income minus expenditures (in billions)	−$4,093	−$3,301	−$2,533

As indicated in Table 6, if the average annual net immigration assumption is 836,000 persons, the deficit—expressed in present-value dollars—increases by $792 billion. Conversely, if the assumption is 1,733,000 persons, the deficit decreases by approximately $769 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.

HHS implements corrective actions including health plan training, Risk Adjustment Data Validation (RADV) audits, and investigations to identify potential fraud and recover overpayments. In FY 2025, HHS launched RADV audits for Payment Years (PYs) 2018-2019 and released audit results for PYs 2011-2013.[3] HHS also began processing appeals submitted by MAOs in response to the PYs 2011-2013 audit results.

Medicare Prescription Drug Benefit (Part D)

HHS estimated 4.00 percent improper payments in Medicare Part D, totaling $4.23 billion. The primary root cause was missing or insufficient documentation submitted by plan sponsors to support prescription drug event data which determines payment. HHS updated its improper payment sampling and estimation methodology plan by using a random beneficiary sample to provide greater year-to-year variation and more representative results for the Medicare Part D population. Medicare Part D improper payment data is available on the Medicare Part D Improper Payment Measurement website.

HHS implements corrective actions including health plan training, audits of high-risk drugs, and investigations to identify potential fraud and recover overpayments. For example, HHS educates plan sponsors on emerging fraud, waste, and abuse schemes and drug trends by issuing Health Plan Management System memos on high-risk drugs, audit findings, and best practices. These efforts strengthen fraud, waste, and abuse programs and ensure compliance with HHS requirements.

Medicaid

HHS estimated 6.12 percent improper payments in Medicaid, totaling $37.39 billion. The national Medicaid improper payment estimate includes three components: Medicaid Fee-for-Service, Medicaid Managed Care, and Medicaid Eligibility. For more information on Medicaid measurement, see the Payment Error Rate Measurement (PERM) website.

The increase in estimated improper payments compared to RY 2024 reflected more errors in eligibility redeterminations and provider screening as states began unwinding from the COVID-19 public health emergency and phasing out enrollment flexibilities. The primary root causes were missing or insufficient documentation and state noncompliance with federal requirements. Missing or insufficient documentation accounts for the most significant portion of improper payments and occurred when states did not provide required eligibility verifications, such as income or resource checks, or when medical records lacked information needed to support medical necessity. Additional state noncompliance included inadequate screening of newly enrolled providers, payments to providers not enrolled, and claims paid without the required national provider identifier.

HHS continued to work with states to independently verify cases where states lacked 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. When HHS verified information not maintained by the state and confirmed the payment was proper, the payment was classified as a technically improper payment (344 cases deemed technically improper of the 1,017 cases eligible for independent verification over the past three measurement cycles).

[3] In 2018, HHS proposed to codify the RADV audit methodology. After two Federal Register extensions and delays caused by the COVID-19 public health emergency, HHS issued a final rule in 2023. In 2024, HHS finalized a second rule clarifying RADV reconsideration and appeals policies, and in 2025 issued audit findings for PYs 2011-2013. On September 25, 2025, a judge in the U.S. District Court for the Northern District of Texas vacated certain portions of HHS's 2023 RADV final rule. HHS is evaluating the implications of this decision and will determine whether any potential changes to current and future audits are needed.

HHS implements corrective actions including state-specific Corrective Action Plans, enhanced training through the Medicaid Integrity Institute (MII), technical assistance on screening and enrollment, access to the Death Master File for eligibility checks, and audits of eligibility determinations to strengthen compliance and reduce improper payments. In FY 2025, the MII expanded its educational offerings, including Evaluation/Management and Inpatient coding bootcamps, provider enrollment, Medicaid risk assessment, and HHS-OIG fraud scheme and trend analysis. HHS also automated and streamlined state submission of Medicaid Eligibility Quality Control and PERM Corrective Action Plan data, reducing burden and improving efficiency. HHS continues to provide technical support in areas such as overpayment remittance.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

HHS estimated 7.05 percent improper payments in CHIP, totaling $1.37 billion. The national CHIP improper payment estimate includes three components: CHIP Fee-for-Service, CHIP Managed Care, and CHIP Eligibility. For more information on CHIP measurement, see the PERM website.

The increase in estimated improper payments compared to FY 2024 reflected more errors in eligibility redeterminations and provider screening as states began unwinding from the COVID-19 public health emergency and phasing out enrollment flexibilities. The primary root causes were missing or insufficient documentation, state noncompliance with federal requirements, and improper determinations of beneficiary eligibility. Missing or insufficient documentation accounts for the most significant portion of improper payments and occurred when states did not provide evidence of required eligibility verifications, such as income or resource checks, or when medical records lacked information needed to support medical necessity. Additional state noncompliance included inadequate screening of newly enrolled providers, payments to providers not enrolled, claims paid without the required national provider identifier, and claims paid when creditable third-party insurance was present. Improper eligibility determinations occurred when states made incorrect claims for beneficiaries under Title XXI (CHIP) instead of Title XIX (Medicaid) due to errors in income calculations, household composition, third-party insurance status, or tax filer status.

HHS worked with states to independently verify cases where states lacked documentation to support state actions. When HHS verified information not maintained by the state and confirmed the payment was proper, the payment was classified as technically improper payments (454 cases deemed technically improper of the 855 cases eligible for independent verification over the past three measurement cycles).

HHS implements corrective actions including state-specific Corrective Action Plans, technical assistance on screening and enrollment, enhanced training, and collaboration with states to address CHIP improper payment drivers similar to those in Medicaid.

ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT (APTC)

The Premium Tax Credit has two payment streams: APTC and the Net Premium Tax Credit (Net PTC) claimed on individual tax returns. Total outlays equal APTC payments plus Net PTC claims.[4] HHS measures APTC improper payments and the Internal Revenue Service (IRS) measures Net PTC improper payments. HHS and IRS estimated the combined improper payments for the Premium Tax Credit program at 1.50 percent, totaling $1.13 billion. The combined estimate excludes State-based Exchange payments and Excess APTC repayments.

[4] The Treasury Annual Financial Report can be found at U.S. Department of the Treasury: Agency Financial Report.

HHS estimated 0.89 percent improper payments in the Federally-facilitated Exchange APTC program, totaling $657.46 million. The primary root cause of improper payments were overpayments due to manual errors where the Federally-facilitated Exchange accepted consumer submitted documentation with unacceptable name and date of birth variances to resolve an eligibility verification issue and improperly input information in the income verification tool. The second root cause was technically improper payments, which are situations where payments are made to eligible recipients for correct amounts but failed to satisfy all legally applicable requirements relevant to payment. In these cases, the system failed to conduct a periodic data match required to check Medicare eligibility or enrollment, but the Exchange later confirmed that the applicant was not eligible or enrolled in Medicare and therefore eligible for APTC.

APTC improper payment data is available on the Exchange Improper Payment Measurement website.

HHS partially meets the requirement to publish improper payment estimates for the APTC program because estimates do not yet include payments from State-based Exchanges. In CY 2023, 17 states and the District of Columbia operated State-based Exchanges, administering about $18.37 billion in APTC outlays—approximately 19.93 percent of total APTC payments. HHS intends to begin the State-based Exchange sampling and estimation measurement no earlier than January 1, 2027.

HHS implements corrective actions including automation improvements, enhanced eligibility personnel training, internal and external audits, and risk-based monitoring of agents and brokers to detect and prevent improper payments and protect consumers.

Temporary Assistance for Needy Families (TANF)

Due to statutory limitations under 42 U.S.C. §617, HHS is precluded from requiring states to participate in a TANF improper payment measurement, and therefore no improper payment estimate is reported for RY 2025. While states administer TANF and are responsible for reducing improper payments, HHS supports state program integrity efforts by conducting improper payment and fraud risk assessments, and promoting use of data sources like the Public Assistance Reporting Information System and enforcing use of the Systematic Alien Verification for Entitlements System to help federal, state, and local agencies identify and reduce improper payments.

Foster Care

HHS estimated 5.72 percent improper payments in Foster Care, totaling $74.07 million. The primary root causes were administrative errors by state agencies in case classification and payment processing. HHS implements corrective actions including enhanced training for federal and state reviewers, clearer federal guidance on new Title IV-E requirements, ongoing quality improvement collaborations with states, and detailed reviews of state claims to identify and address errors.

Child Care and Development Fund (CCDF)

HHS estimated 4.93 percent improper payments in CCDF, totaling $921.46 million. The primary root causes were missing or insufficient documentation in case records and administrative errors in applying eligibility policies. HHS will continue to provide ongoing training and technical assistance to support states' efforts to strengthen program integrity including providing cohort webinars, office hours, and intensive technical assistance to individual states that are under an error rate Corrective Action Plan. In addition, states reported plans to take corrective actions including providing guidance or training for eligibility workers, conducting ongoing reviews, reviewing and updating

policies and procedures and manuals, providing direct individual feedback or corrective action to workers, and developing new tools or procedures for eligibility staff.

HEAD START

HHS estimated 10.29 percent improper and unknown payments in Head Start, totaling $1.21 billion. The primary root causes for improper payments were missing or insufficient administrative documentation, particularly in expenditures related to salaries, wages, and fringe benefits. The primary root cause for unknown payments (8.62 percent of total payments, or $1.01 billion) were limitations in verifying transaction level data, including missing or insufficient documentation from sampled funding recipients to determine if the payment is proper. HHS implements targeted corrective actions including enhanced fiscal support and recordkeeping training for grant recipients, updated guidance on required documentation, increased transaction reviews, audits and monitoring for targeted recipients, and recovery actions on identified payment errors.

RECOVERY AUDITS AND ACTIVITIES

HHS conducted recovery audits and activities in Medicare, Medicaid, and other programs to identify and recover overpayments and inform corrective actions.

HHS uses recovery audit results to implement corrective actions, enhance program oversight, and reduce future improper payments. More detailed information on recovery activities and topics approved for RAC review is available at Medicare RAC Program Website.

Table 3 provides information on HHS's overpayment payment recovery results.

Table 3: Overpayments Recovered

RY 2025 (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]				$25.57	$19.25
Medicare FFS Recovery Auditors	$477.17	$369.93	77.53%		
Medicare Part C RADV Audits [3]	$12.99	N/A	N/A		
Medicare Part D Prescription Drug Audits [4]	N/A	$0.60	N/A		
MSP Recovery Auditor	$500.88	$276.99	55.30%		
Medicare Contractors [5]				$16,925.43	$13,284.70
Medicaid Integrity Contractors—Federal Share [6]				$47.48	$31.24
State Medicaid Recovery Auditors—Federal Share [7]	N/A	$59.45	N/A		
ACF Error Rate Measurements [8]				$3.99	$3.92
ACF OIG Reviews [9]				$1.48	$2.57
Single Audits [10]				$138.06	$55.69
TOTAL [11]	**$991.04**	**$706.97**	**71.34%**	**$17,142.01**	**$13,397.37**

Notes:

1. Unless otherwise noted, the amount reported in the Amount Recovered column is the amount recovered in FY 2025, regardless of the year HHS identified the overpayment.
2. This row includes recoveries from Medicare FFS (via the Comprehensive Error Rate Testing (CERT) program), as well as Medicaid and CHIP (via the PERM program). The overpayments identified in the CERT sample for RY 2025 were $24,353,394.62. The MACs recover these overpayments via standard payment recovery methods. As of October 2025, MACs reported collecting $18,628,101.09 or 76.49 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 2025 were $325,241.78 for Medicaid and $894,583.16 for CHIP. HHS recovered $544,590 for Medicaid and $75,392 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. Only the amount recovered is available. HHS expects to begin issuing PY 2018 audit findings in mid-calendar year 2026, including instructions on how the overpayments will be collected.
4. As these recoveries are the result of PPI-MEDIC's national audits and Part D plan sponsor self-audits, the amounts identified are not included.
5. 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.
6. 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.
7. 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.
8. Amount Identified information comes from the reviews underlying the RY 2025 estimates for the CCDF, Foster Care, and Head Start programs Amounts Recovered may include recoveries based on FY 2025 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 $98,946 to the Amount Identified and $34,214 to the Amount Recovered, representing improper payments recovered in FYs 2022 through 2024 by the Year Three states based on reviews for RY 2022. As a result of conducting Foster Care eligibility reviews in 20 states and revised findings for 2 states, HHS identified and recovered $3,886,892 in Title IV-E improper payments (comprised of $2,128,570 in disallowed maintenance payments and $1,758,322 in disallowed administrative payments). For Head Start, HHS identified $318.33 in improper payments during reviews for RY 2025. No recoveries have been made at this time. However, HHS is continuing recoveries in FY 2026 for the program through the disallowance process.
9. 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, 2024 and July 31, 2025.
10. This row includes information for all Divisions and represents results for the full FY 2024.
11. Totals do not necessarily equal the sum of the rounded component.

COMPLIANCE STATEMENT

HHS met many requirements but was not fully compliant with PIIA in FY 2025. Additional details on program compliance and reported improper payment results are available on PaymentAccuracy.gov.

FY 2025 Top Management and Performance Challenges Identified by the Office of Inspector General

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20501

DATE: January 7, 2026

TO: Robert F. Kennedy, Jr.
Secretary

THROUGH: Liesl I. Fowler
Executive Secretary

FROM: T. March Bell
Inspector General

SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2025

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 (the Department) in fiscal year 2025. 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.

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

2025

Department of Health and Human Services

Office of Inspector General

Contents

Introduction

The Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) issues its *Top Management and Performance Challenges Facing HHS* annually as required by statute. This publication is intended to help the Department improve the effectiveness and efficiency of its programs and operations. This past year, the Department has undertaken a sizeable workforce reduction and many program changes are in process. Effectively managing a changing organizational and workforce environment is itself a significant management challenge. Concurrently, the Department faces five top challenges, which are summarized in the sections that follow. While the Department has taken steps to address these five challenges, 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.

1 | Financial Integrity

Elements of the Challenge

- Preventing, reducing, and recovering improper payments
- Controlling costs by ensuring prudent payments
- Protecting grants and contracts from fraud
- Monitoring and reporting on the integrity of HHS financial management

Given HHS's significant expenditures, the Department must ensure sound financial stewardship and work to combat fraud, waste, and abuse.

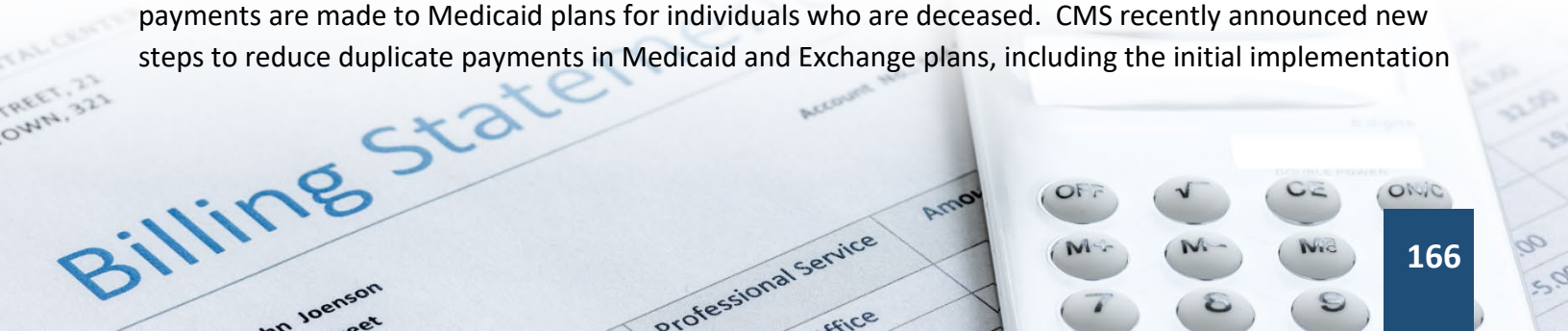
Preventing, Reducing, and Recovering Improper Payments

In fiscal year (FY) 2024, improper payments for Medicare, Medicaid, and the Children's Health Insurance Program were estimated at $86.5 billion. An improper payment is any payment that does not meet legal requirements or is made in an incorrect amount. Among other harms, improper payments can duplicate other payments, fund ineligible services, enrich ineligible providers, serve ineligible recipients, or violate other program rules. HHS must be vigilant in recovering overpayments promptly.

- Within the Traditional Medicare program, reducing improper payments remains a challenge. The improper payment rate reported in FY 2024, 7.66 percent, has not decreased from the rates reported in FYs 2022 or 2023. The four categories with the largest dollars in improper payments in FY 2024 were claims associated with skilled nursing facilities, hospital outpatient services, inpatient rehabilitation facilities, and hospice care. The Centers for Medicare & Medicaid Services (CMS) has developed multiple corrective actions to address these errors, including audits of high overpayment areas and provider education to reduce claim errors. OIG has identified additional areas of high risk, such as payments to critical access hospitals.

- In the Medicaid program, the improper payment rate reported in FY 2024, 5.09 percent of all payments, was a decrease from 8.58 percent in FY 2023. The rate is based on a rolling average of the three prior payment years. The decrease is likely due to a combination of factors, including improved State compliance and temporary flexibilities from the COVID-19 public health emergency that allowed for suspensions of eligibility checks, eliminating that as a source of error.

- Ensuring accuracy of eligibility and enrollment data is a challenge in the Medicaid program. OIG audits have shown that individuals are concurrently enrolled in Medicaid programs in two different States, and payments are made to Medicaid plans for individuals who are deceased. CMS recently announced new steps to reduce duplicate payments in Medicaid and Exchange plans, including the initial implementation



of some tools provided in the One Big Beautiful Bill Act to prevent duplicate enrollment. Ensuring that all of the new tools established by the One Big Beautiful Bill Act operate effectively will require CMS to coordinate closely with the States over the next several years.

- HHS awards grants and contracts to deliver programs and services. HHS must be vigilant in ensuring that these awards meet their objectives efficiently and effectively and that they comply with Federal requirements. The Department needs to continue its progress to ensure that grant and contract dollars are used for their intended purpose, and recipients properly account for costs and justify expenditures. This includes ensuring sufficient visibility into subawards of grant funds and improving the contract management and closeout processes.

Controlling Costs by Ensuring Prudent Payments

HHS must continually assess payment policies to ensure they are structured to curb wasteful spending. OIG work has identified payment policies that create incentives for providers and other stakeholders to behave in ways that increase costs to HHS programs without adding value. For example, for skin substitutes used for wound care, a combination of low barriers to market entry and reimbursement at rates higher than acquisition costs, or spread pricing, drive both higher prices and increased utilization, resulting in higher Medicare costs. Similar issues exist for continuous glucose monitors, creating incentives for increased utilization. CMS has recently proposed regulations to reform payments for skin substitutes and continuous glucose monitors. HHS must continue to pursue cost savings by identifying and correcting misaligned payment policies to ensure that HHS programs are prudent purchasers of items and services.

Protecting Grants and Contracts From Fraud

Fraud is a threat to grant and contract awards. HHS must be vigilant in ensuring that taxpayer investments in HHS grants and contracts are not diverted for fraudulent, unauthorized, or illegal purposes. The Department must continue to enhance oversight, internal controls, and fraud detection measures to guard against increasingly complex, technology-driven national and transnational fraud schemes. Key risks include embezzlement, social engineering schemes, identity theft, diversion of funds for personal use, and submission of false information for fraudulent purposes.

Monitoring and Reporting on the Integrity of HHS Financial Management

Effective internal controls are needed to prevent fraudulent transactions and prevent bad actors from gaining access to HHS systems. 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, the Department must take additional actions to resolve ongoing issues, including continuing efforts to monitor access to key applications and ensuring appropriate segregation of duties.

Examples of Related Work

- *Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths*
- *ACF Used Contractor Personnel To Perform Inherently Governmental Functions and Paid Millions in Potentially Unallowable Costs*
- *Nearly All States Made Capitation Payments for Beneficiaries Who Were Concurrently Enrolled in a Medicaid Managed Care Program in Two States*
- *Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System*
- *Medicare Part B Payment Trends for Skin Substitutes Raise Major Concerns About Fraud, Waste, and Abuse*
- *NIH Did Not Close Contracts in Accordance With Federal Requirements, Resulting in the Increased Risk of Fraud, Waste, and Abuse*

2 | Medicare and Medicaid

Elements of the Challenge

- Combating fraud, waste, and abuse
- Ensuring Medicare Advantage delivers value
- Ensuring the effectiveness and efficiency of the Medicaid program

Millions of American seniors, individuals with disabilities, people in low-income households, and individuals with disease and other complex health needs rely on Medicare and Medicaid for health care coverage. HHS must ensure that these programs deliver high-quality, cost-effective care.

Combating Fraud, Waste, and Abuse

Combating fraud, waste, and abuse in Medicare and Medicaid is imperative to ensure that every dollar invested in these programs is used to provide high-quality health care. CMS partnered effectively with OIG to suspend billions of dollars in payments to suspected fraud perpetrators as part of the 2025 National Health Care Fraud Takedown and launched a Fraud Defense Operations Center. CMS must build on these important steps and continue to improve its ability to stop improper and fraudulent payments. These efforts should focus on fraud prevention (e.g., provider enrollment screening and revalidation), detection (e.g., claims processing, pre-payment review, data analysis), and administrative enforcement actions (e.g., payment suspension, recovery of overpayments, termination, revocation). CMS should consider additional program-specific safeguards, such as including ordering providers' National Provider Identifiers on managed care claims. CMS should continue to work closely with its contractors and with OIG and other law enforcement partners to detect and prevent fraud.

Fraud schemes are increasingly complex and global in scope, often migrating from one item or service to another. Items and services at high risk of fraud include durable medical equipment, prescription drugs, hospice care, genetic and clinical laboratory testing, wound care, and treatment for substance use disorder. In designing safeguards, CMS should also consider the roles of for-profit ownership, vertical integration, and middlemen (e.g., pharmacy benefit managers) in potential fraud, waste, and abuse in health care. 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.

Ensuring Medicare Advantage Delivers Value

Medicare Advantage has become the primary method through which Medicare enrollees receive care. Administering a program of this size (nearly 33 million enrollees and $462 billion in Federal spending in calendar year 2024) presents challenges in ensuring that payments are accurate, and people enrolled have access to needed care that plans are being paid to provide. HHS must continue to strengthen protections to ensure that plans are not upcoding to receive increased risk adjustment payments or making it difficult for enrollees to receive covered care by denying claims or implementing excessive prior authorization requirements. HHS recently announced a new initiative to improve prior authorization processes. Rigorous oversight will be needed to ensure that enrollees receive appropriate care without undue administrative or financial burden and that plans are delivering value to the taxpayers funding this care. Oversight is also needed to ensure plans are not inappropriately denying payment to providers and are not engaged in misleading and deceptive marketing or enrollment practices. Finally, additional attention must be paid to ensuring that complete and accurate data about payments are readily available from plans for effective monitoring and oversight of the Medicare Advantage program.

Ensuring the Effectiveness and Efficiency of the Medicaid Program

OIG work has identified vulnerabilities in the Medicaid program related to payment accuracy, eligibility determinations, provider taxes, and service delivery. As it plans for and administers significant changes in the Medicaid program under the One Big Beautiful Bill Act, CMS should consider these vulnerabilities and adopt appropriate safeguards to ensure that the program operates as intended. Risk areas include ensuring transparency, accurate data, correct eligibility determinations, timely return of overpayments, and access to covered care, particularly in rural areas. Because Medicaid is jointly administered and financed, effective coordination and communication between the Federal Government and States is especially critical as CMS implements new program requirements. As it implements these requirements, CMS must continue to address vulnerabilities in the current program.

Examples of Related Work

- *Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions*
- *Special Fraud Alert: Suspect Payments in Marketing Arrangements Related to Medicare Advantage and Providers*
- *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*
- *CMS Is Not Systematically Tracking Whether States Return Federal Shares of Medicaid Managed Care Remittances*
- *Indiana Made at Least $56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism*

3 | Public Health

Elements of the Challenge

- Preventing and fighting chronic disease
- Addressing the mental health and substance use disorder crises
- Ensuring the safety, effectiveness, and availability of products regulated by the Food and Drug Administration

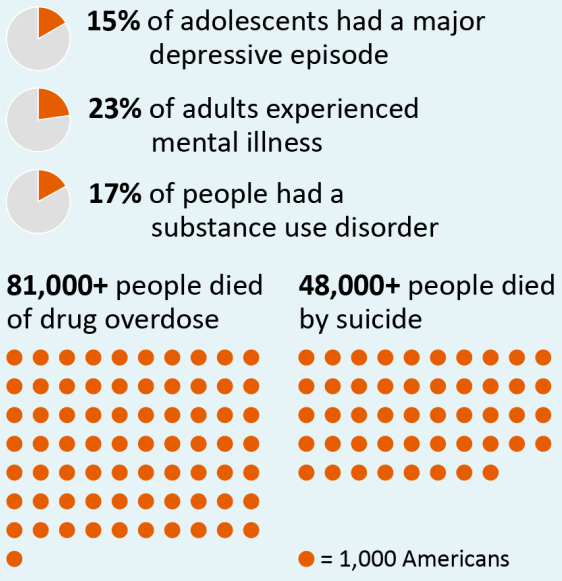
HHS must efficiently use public health resources to protect and improve the health of all Americans.

Preventing and Fighting Chronic Disease

According to the Centers for Disease Control and Prevention, chronic diseases such as heart disease, cancer, and diabetes are the leading causes of illness, death, and disability in the United States. They are also leading drivers of the Nation's $4.9 trillion in annual health care costs. Approximately 6 in 10 Americans have at least one chronic disease, and 4 in 10 have two or more chronic diseases. Rates of chronic disease in children are rising. HHS has expressed a commitment to getting to the root cause of and combating the chronic disease epidemic. HHS is leading the Make America Healthy Again Commission, which released an assessment of chronic disease in children and its strategy to combat childhood chronic disease. Much remains to be done to address the considerable challenge of preventing and fighting chronic disease.

Addressing the Mental Health and Substance Use Disorder Crises

In 2024, 15.4 percent of American adolescents had a major depressive episode, 23.4 percent of American adults experienced mental illness, and 16.8 percent of Americans older than 12 had a substance use disorder. In 2024, an estimated 48,821 Americans died by suicide and an estimated 81,711 Americans died from drug overdoses. While this represents a notable decrease in overdose deaths compared to 2023 when an estimated 106,903 people died, these numbers remain higher than recorded before 2020.



The difficulty in obtaining timely, high-quality care for mental health and substance use remains an obstacle in effectively addressing the Nation's mental health and substance use disorder crises. As HHS considers changes to programs that provide behavioral health care and support, addressing the substance use disorder and mental health crises is a continuing challenge.

Ensuring the Safety, Effectiveness, and Availability of Products Regulated by the Food and Drug Administration

The Food and Drug Administration (FDA) regulates crucial consumer products, including foods, human and veterinary drugs, biological products, medical devices, 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, and cyberattacks and other security risks. While faced with these challenges, FDA must ensure the safety, effectiveness, quality, security, and availability of FDA-regulated products.

Examples of Related Work

- *Medicare Part D Spending for 10 Selected Diabetes Drugs Totaled $35.8 Billion in 2023, an Increase of 364 Percent From 2019*
- *Medicaid Gross Spending on 10 Selected Diabetes and 2 Selected Weight Loss Drugs Totaled More Than $9 Billion in 2023, an Increase of 540 Percent From 2019*
- *Medicare and Medicaid Enrollees in Many High-Need Areas May Lack Access to Medications for Opioid Use Disorder*
- *FDA Food Safety Inspections of Domestic Food Facilities*
- *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*

4 | Beneficiary Safety

Elements of the Challenge

- Protecting the health and safety of those served
- Ensuring qualified providers and other staff

People receiving HHS-funded care should be able to trust that they will be protected from preventable harms.

Protecting the Health and Safety of Those Served

HHS-funded programs and services are operated in a variety of different settings, including hospitals, nursing homes, adult day care facilities, hospices, shelters for unaccompanied alien children, child care centers, foster care group homes, and people's own homes, among many others. HHS programs have a role in protecting the health and safety of those served, including protecting against abuse in child care settings, infections in hospitals, misuse of drugs in nursing homes, and hazards in adult day care facilities. To that end, providers and program managers must follow health and safety requirements, appropriately vet and train staff, and identify and quickly remediate weaknesses that put individuals at risk.

Every year, millions of patients served by Federal health programs experience adverse events and temporary harm events as a result of medical care or in a health care setting. Some of these events are the result of errors or substandard care. Although most harm events resolve quickly, some have long-term and serious implications for patient health. HHS has uncovered practices that put organ donors at risk for preventable harm. Despite nationwide efforts to improve patient safety, reducing patient harm remains a challenge for HHS.

People in nursing homes are at increased risks for harm. HHS has taken important steps to improve nursing home safety and must continue to build on this progress, in areas such as infection control, drug misuse, improper facility-initiated discharges, and preventing abuse and neglect.

Emergency situations, often fast moving, uncertain, and complicated, can both introduce new and exacerbate longstanding gaps in safety and put those most vulnerable to harms at greater risk of injury or death. For natural disasters, emerging infectious diseases, bioterrorism, or other life safety events, HHS must strengthen its efforts to protect beneficiaries during and after emergencies.

Ensuring Qualified Providers and Other Staff

Thousands of HHS-funded providers and program staff hold positions of trust that bring them into close contact with individuals, often behind closed doors. Most providers and other staff earn this trust and work hard to serve people well; however, some cause harm. Thoroughly vetting providers and staff by using background checks helps prevent potential predators, and people otherwise disqualified, from gaining access to individuals in HHS programs. Gaps in compliance with background check requirements in HHS-funded programs remain, increasing the potential for preventable harms, particularly among populations at greatest risk, including children, older Americans, and people with special health care needs. The Department must remain vigilant in continuous efforts to ensure that HHS-funded providers and other staff, in all program and service settings, meet established criteria for vetting and training.

Examples of Related Work

- *Hospitals Did Not Capture Half of Patient Harm Events, Limiting Information Needed To Make Care Safer*
- *Concerns Remain About Safeguards To Protect Residents During Facility-Initiated Discharges From Nursing Homes Many States Lack Information To Monitor Maltreatment in Residential Facilities for Children in Foster Care*
- *2023 Operation Nightingale Enforcement Action*
- *CMS Should Take Additional Actions To Help Hospitals Prepare for a Future Emerging Infectious Disease Outbreak*
- *State Survey Agencies Need Additional Guidance To Assess Nursing Home Emergency Preparedness Programs*
- *Gallup Indian Medical Center—an IHS-Operated Health Facility—Did Not Timely Conduct Required Background Checks of Staff and Supervise Certain Staff*

5 | Cybersecurity

Element of the Challenge

- Improving cybersecurity for HHS programs, related industry sectors, and individuals

HHS must adapt as risks expand to include social engineering threats, data breaches, and increasingly sophisticated cyberattacks.

HHS faces persistent cybersecurity threats. 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 division and program.

Improving Cybersecurity for HHS Programs, Related Industry Sectors, and Individuals

Cyberattacks and related threats can jeopardize critical HHS operations and programs, potentially compromising the health and welfare of the individuals HHS serves. Disparate organizational approaches to cybersecurity that vary by division and program within the Department and across the Government complicate HHS's preparedness efforts to prevent or respond to cybersecurity risks. The Department has taken steps to consolidate functions related to cybersecurity and improve its cybersecurity overall, but progress is often still dependent on each division and program.

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 solutions that mitigate cybersecurity threats specific to their operations, which may be more challenging for smaller entities. Protecting technology and data requires broader efforts beyond implementing technical fixes, such as establishing clear expectations; modernizing program rules; and conducting effective oversight of the Department's contractors, grantees, and other external entities.

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. Bad actors continue to leverage the threat of interrupting patient care and other critical health care operations to extract ransoms or other value from 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.

Although HHS leads a network of Federal agencies to improve the cybersecurity of the health care and public health sectors, 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 and security of individual data that is required to receive services, and that must be kept out of the hands of bad actors. 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 of protecting health information or increased risks to the security of electronic protected health information. Working within the statutory authorities established by HIPAA in 1996, HHS must adapt as privacy and security needs evolve.

Examples of Related Work

- *HHS's Grant Payment System Lacked Effective Internal Controls To Prevent $7.8 Million in Fraud, and HHS Has Begun Taking Corrective Actions To Reduce Fraud Risk*
- *Summary Report of Prior Office of Inspector General Cyber Threat Hunt Audits of Eight HHS Operating Division Networks*
- *Illumina Inc. to Pay $9.8M to Resolve False Claims Act Allegations Arising from Cybersecurity Vulnerabilities in Genomic Sequencing Systems*
- *A Large Northeastern Hospital Could Improve Certain Security Controls for Preventing and Detecting Cyberattacks*
- *The Office for Civil Rights Should Enhance Its HIPAA Audit Program To Enforce HIPAA Requirements and Improve the Protection of Electronic Protected Health Information*
- *HHS Office of the Secretary Needs To Improve Key Security Controls To Better Protect Certain Cloud Information Systems*

Conclusion

Addressing HHS's top management and performance challenges will support high-quality care and services, ensure careful stewardship of taxpayer dollars, and mitigate fraud and other risks so that programs operate as intended.

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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 of 1974, 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's Response to the Office of Inspector General

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Deputy Secretary

To: T. March Bell, Inspector General

From: Jim O'Neill, Deputy Secretary

Subject: Fiscal Year 2025 Top Management and Performance Challenges Facing HHS

On behalf of the Department of Health and Human Services (HHS), we appreciate the Office of Inspector General's (OIG) continued efforts to identify the five top management and performance challenges. The OIG audits and oversight activities this past year have strengthened HHS operations, benefiting our stakeholders and the people who rely on HHS to enhance their health and well-being.

We appreciate the OIG's recommendations and remain committed to addressing these challenges and other key issues facing HHS. We will continue advancing innovations in public health, beneficiary safety, data security, and technology, while safeguarding program operations and financial integrity to better support HHS's critical functions.

We look forward to our continued partnership with the OIG as we advance fiscal accountability for a healthy America by strengthening sound financial management and program operations, ultimately improving the health and well-being of those we serve.

/Jim O'Neill/

Jim O'Neill
Deputy Secretary
January 14, 2026

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SECTION 4 APPENDICES

- APPENDIX A: ACRONYMS
- APPENDIX B: CONNECT WITH HHS

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Appendix A: Acronyms

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
ASPA	Office of the Assistant Secretary for Public Affairs
ASPR	Administration for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
CCDF	Child Care and Development Fund
CDC	Centers for Disease Control and Prevention
CFO	Chief Financial Officer
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COLA	Cost of Living Adjustment
COVID-19	Coronavirus Disease
CPI	Consumer Price Index
CSRS	Civil Service Retirement System
CX	Customer Experience
DAB	Departmental Appeals Board
DATA Act	*Digital Accountability and Transparency Act of 2014*
DOI	Department of the Interior
DOL	Department of Labor
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
FICA	*Federal Insurance Contributions Act*
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FR	Financial Report of the United States Government
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GDP	Gross Domestic Product
G-Invoicing	Government Invoicing
Grants QSMO	Grants Quality Service Management Office
GTAS	Governmentwide Treasury Account Symbol Adjusted Trial Balance System
HHS	Department of Health and Human Services
HI	Hospital Insurance
HRSA	Health Resources and Services Administration
IBNR	Incurred But Not Reported
IHS	Indian Health Service
IP	Improper Payments
IRA	*Inflation Reduction Act*
IT	Information Technology
MA	Medicare Advantage
MDH	Medicare-Dependent Hospital
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
OPM	Office of Personnel Management
OS	Office of the Secretary
Part A	Hospital Insurance
Part B	Medical Insurance
Part C	Medicare Advantage
Part D	Medicare Prescription Drug Benefit
PHS	Public Health Service
PIIA	*Payment Integrity Information Act of 2019*
PP&E	Property, Plant and Equipment
PPACA	*Patient Protection and Affordable Care Act*
PSC	Program Support Center
RADV	Risk Adjustment Data Validation
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
SNS	Strategic National Stockpile
SOSI	Statement of Social Insurance

Acronyms

SSA	Social Security Administration
SSF	Service and Supply Funds
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
U.S.	United States
U.S.C.	United States Code
UPIC	Unified Program Integrity Contractors
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 2025 AFR. We could not have prepared this year's report without the talent, time, and dedication of employees across the Department of Health and Human Services.

Electronic copies of this report 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:

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