Section I: Management's Discussion and Analysis

Mission and Organizational Structure

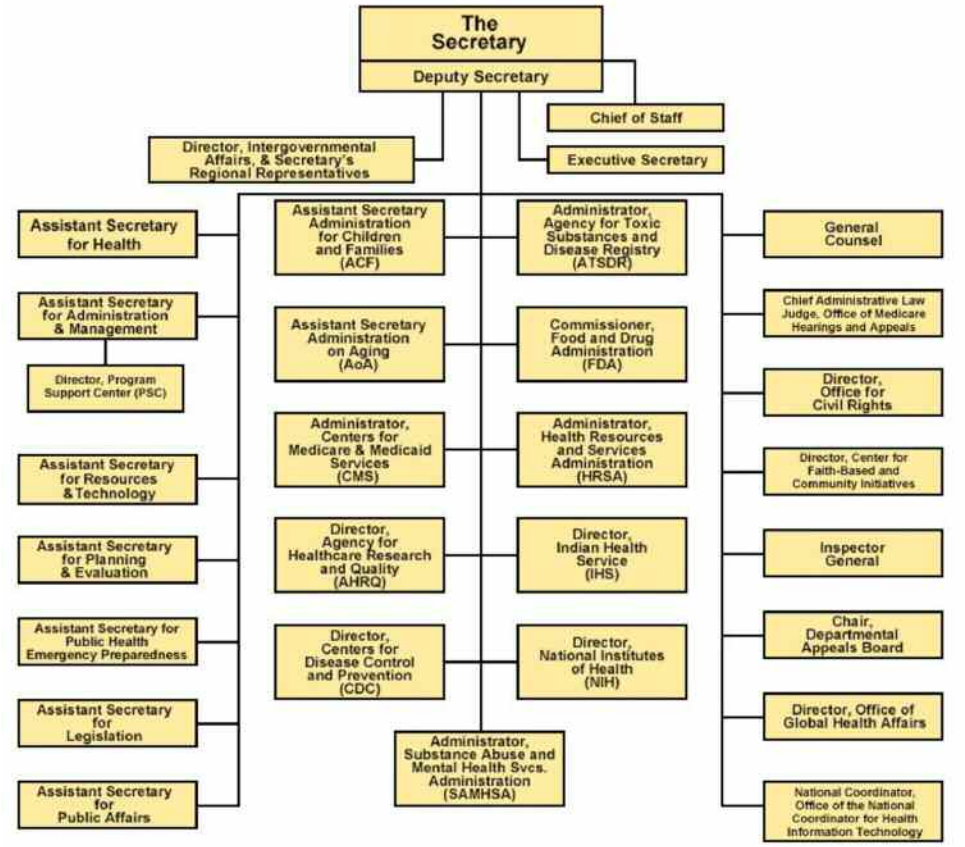
Mission

The mission of the Department of Health and Human Services (HHS) is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences, underlying medicine, public health, and social services.

At the Department, our number one priority will always be to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves.

Organizational Structure

The Secretary leads a Department that provides a wide range of services and benefits to the American people. Below is an organizational chart, followed by a brief overview of each major Departmental component. (Click on the title of the highlighted organization to access that component's website.)



Major Departmental Components

Administration for Children and Families (ACF) www.acf.hhs.gov

ACF is responsible for programs that promote the economic and social well-being of children, families, and communities. ACF administers the Temporary Assistance to Needy Families program; the Head Start program, which serves pre-school children; and the National Child Support Enforcement System which collects billions of dollars in payments from non-custodial parents. Additionally, ACF provides funds to assist low-income families in paying for child care, to support state programs for foster care and adoption assistance, and to support programs that prevent child abuse and domestic violence.

Administration on Aging (AoA) www.aoa.gov

AoA supports a nationwide aging network, providing services to the elderly, especially to enable them to remain independent. AoA supports meals for the elderly each year, including home-delivered "meals on wheels." AoA also helps provide transportation and at-home services, supports ombudsman services for the elderly, and provides policy leadership on aging issues.

Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov

AHRQ supports research on healthcare systems, quality, cost issues, access, and effectiveness of medical treatments. AHRQ also provides evidence-based information on healthcare outcomes and quality of care.

Agency for Toxic Substances and Disease Registry (ATSDR) www.cdc.gov

The Centers for Disease Control and Prevention director is also administrator of the ATSDR. ATSDR helps prevent exposure to hazardous substances from waste sites on the U.S. Environmental Protection Agency's National Priorities List, and develops toxicological profiles of chemicals at these sites.

Centers for Disease Control and Prevention (CDC) www.cdc.gov

CDC, working with states and other partners, provides a system of health surveillance to monitor and prevent disease outbreaks (including bioterrorism), and implement disease prevention strategies, and environmental disease prevention. CDC also guards against international disease transmission with personnel stationed in many countries.

Centers for Medicare & Medicaid Services (CMS) www.cms.gov

CMS administers the Medicare and Medicaid programs, which provide healthcare to about one in every four Americans. Medicare provides health insurance for elderly and disabled Americans. Medicaid, a joint Federal-state program, provides health coverage for certain groups of low-income individuals. CMS also administers the State Children's Health Insurance Program.

Food and Drug Administration (FDA) www.fda.gov

FDA assures the safety of foods and cosmetics, and the safety and efficacy of pharmaceuticals, biological products, and medical devices—products which represent almost 25 cents out of every dollar in U.S. consumer spending.

Health Resources and Services Administration (HRSA) www.hrsa.gov

HRSA provides access to essential healthcare services for people who are low-income, uninsured, or who live in rural areas or urban neighborhoods where healthcare is scarce. HRSA supports comprehensive primary care services; helps prepare the Nation's healthcare system to respond to bioterrorism and other public health emergencies; maintains the National Health Service Corps; and helps build the healthcare workforce through training and education programs. HRSA also administers a variety of programs to improve the health of mothers and children and to serve underinsured people living with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) through the Ryan White Comprehensive AIDS Resources Emergency Act programs. HRSA also oversees the Nation's organ transplant system.

Indian Health Service (IHS) www.ihs.gov

IHS provides health services to American Indians and Alaska Natives of federally recognized tribes. The Indian health system includes hospitals, health centers, health stations, satellite clinics, residential substance abuse treatment centers, Alaska Native village clinics, and urban Indian health programs.

National Institutes of Health (NIH) www.nih.gov

NIH is the world's premier medical research organization, supporting research projects nationwide in diseases including cancer, Alzheimer's, diabetes, heart ailments, and Acquired Immunodeficiency Syndrome.

Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov

SAMHSA works to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. It provides funding through grants to states and communities to support substance abuse and mental health services, including treatment for individuals with serious substance abuse or mental health problems. Additionally, SAMHSA helps improve substance abuse prevention and treatment services through the identification and dissemination of best practices, and monitors the prevalence and incidence of substance abuse.

Program Support Center www.psc.gov

PSC is a component of the Assistant Secretary for Administration and Management that provides support services to the Departmental components and other Federal departments and agencies. The PSC offers many products and services on a fee-for-service basis to government entities across the Nation.

Office of the Secretary

Departmental leadership is provided by the Office of the Secretary. Also included in the Department is the Office of Public Health and Science, the Office of Inspector General, the Office of Civil Rights, the Office of the Coordinator for Health Information Technology, and the Office of Medicare Hearings and Appeals.

Strategic Goals

To carry out its mission, the Department articulated eight strategic goals in its FY 2004 - FY 2009 Strategic Plan. The eight strategic goals are:

Goal 1. Reduce the major threats to the health and well-being of Americans
Goal 2. Enhance the ability of the Nation's healthcare system to effectively respond to bioterrorism and other public health challenges
Goal 3. Increase the percentage of the Nation's children and adults who have access to healthcare services, and expand consumer choices
Goal 4. Enhance the capacity and productivity of the Nation's health science research enterprise
Goal 5. Improve the quality of healthcare services
Goal 6. Improve the economic and social well-being of individuals, families, and communities, especially those most in need
Goal 7. Improve stability and healthy development of our Nation's children and youth
Goal 8. Achieve excellence in management practices

HHS administers more than 300 programs, covering a wide spectrum of activities. Some highlights include:

- Health and social science research
- Preventing disease, including immunization services
- Assuring food and drug safety
- Medicare (health insurance for elderly and disabled Americans) and Medicaid (health insurance for low-income people)
- Health information technology
- Financial assistance and services for low-income families
- Improving maternal and infant health
- Head Start (pre-school education and services)
- Faith-based and community initiatives
- Preventing child abuse and domestic violence
- Substance abuse treatment and prevention
- Services for older Americans, including home-delivered meals
- Comprehensive health services for Native Americans
- Medical preparedness for emergencies, including potential terrorism

Secretary Leavitt established a 500-Day Plan to achieve the Department's strategic goals and to provide a management tool for guiding its energies toward fulfilling the President's vision to improve the health and quality of life for our fellow Americans. The plan offers a core set of public policy principles that form the philosophical standard to uphold fiscal responsibility and good stewardship. It provides the Department a prism through which those who work with the Secretary look to: determine how best to approach goals associated with transforming the U.S. healthcare system; modernize Medicare and Medicaid; advance medical research; help to secure the Homeland; protect life, family and human dignity; as well as improve the human condition around the world.

The strategies in the plan focus on actions during a rolling 500-day period that will achieve significant progress for the American people over a 5,000-day horizon. A 250-day update has been prepared to reflect the values in the original 500-day plan. The Program Performance Overview and the Strategic Goal Highlights in this section, and the Performance Report in Section II, provide examples of accomplishments and other information related to the individual strategic goals.

HHS' FY 2004 - FY 2009 Strategic Plan can be viewed at http://aspe.hhs.gov/hhsplan/. For more information on the 500-Day Plan: 250-Day Update, visit http://www.hhs.gov/500DayPlan/250update.html.

Strategic Goal Highlights

The Department accomplishes its eight strategic goals and implements the Secretary's 500-Day Plan by managing and delivering hundreds of programs across several disciplines. The Department's ability to meet the health and human service needs of Americans is tied directly to the commitment, cooperation, and success generated by its employees and partners that include other Federal agencies, state and local governments, tribal organizations, community-based organizations, faith-based organizations, and the business community. Highlights on various activities carried out by the Department as they relate to the strategic goals are as follows:

Strategic Goal 1. Reduce the major threats to the health and well-being of Americans

The Center for Disease Control and Prevention (CDC) has begun a crosscutting approach to improving adolescent health through the development and implementation of adolescent health protection goals. More than 20 divisions within six National Centers are involved in better integration of adolescent health activities across the agency. Existing activities related to adolescents include school health programs, motor vehicle safety, and immunizations. For example, the Advisory Committee on Immunization Practices recently recommended the first vaccine developed to prevent cervical cancer and other diseases in females caused by certain types of genital human papillomavirus. Additionally, CDC promoted the uptake of a newly improved vaccine to prevent acellular pertussis among adolescents.

The Agency for Toxic Substances and Disease Registry (ATSDR) measures the effectiveness of its interventions by documenting the reduced occurrence or risk of health effects at sites with documented exposures. ATSDR tracks the sites where human health risks or disease have been mitigated. Since FY 2004, ATSDR determined that its efforts had mitigated health risks or disease at 54 percent of its urgent and public health hazard sites. ATSDR selects the most appropriate measure(s) for each site that poses an urgent or public health hazard. These measures include comparative morbidity/mortality rates, biomarker tests, levels of environmental exposures, and/or behavior change of community members and/or health professionals.

ATSDR also responds to toxic substance releases when they occur or as they are discovered and provides recommendations for protecting public health to the U.S. Environmental Protection Agency, state regulatory agencies, or private agencies. As a non-regulatory agency, ATSDR is able to prevent or mitigate exposures most effectively when these other agencies adopt and implement its recommendations. ATSDR has reported 4 consecutive years of performance data showing an increase in the percentage of adopted recommendations.

The Department is coordinating and mobilizing resources at the local, state, and national levels to prepare and protect the American public from an influenza pandemic. The President signed legislation that provides $3.3 billion to HHS to expand

domestic capacity for, and stockpiles of, vaccines; to fund cell-based approach to producing influenza vaccines; to procure and stockpile antiviral drugs; to enhance local and state preparedness; and to improve domestic and international surveillance efforts. For the first time, a vaccine was developed that produced an immune response against an avian flu virus.

Strategic Goal 2. Enhance the ability of the Nation's healthcare system to effectively respond to bioterrorism and other public health challenges

HHS established a Health Information Technology Federal Advisory (FACA) Committee to develop critical breakthroughs that will help lead to fewer medical errors, improved deficiencies and better health outcomes. HHS will help develop the infrastructure, including prototypes for a nationwide health information network that will allow secure and seamless exchange of information while protecting confidentiality. This work is complemented by proposed rules permitting healthcare organizations to furnish hardware, software, and related training services to physicians for e-prescriptions and for electronic health records. HHS is coordinating related efforts with the Department of Veterans Affairs, Department of Defense, and the Office of Personnel Management.

In response to the emerging threat of pandemic influenza, the Food and Drug Administration (FDA) announced the formation of a Rapid Response Team to ensure that antiviral drugs are available to the American people, in the event they are needed. By using the Rapid Response Team approach, FDA estimates it could review a complete drug application in 6 to 8 weeks. In partnership with the Centers for Disease Control and Prevention, the National Institutes of Health, and industry, the Rapid Response Team will work to ensure every necessary measure is taken to provide an adequate and timely supply of antiviral drugs to treat avian flu, if it should emerge in the United States.

Strategic Goal 3. Increase the percentage of the Nation's children and adults who have access to healthcare services, and expand consumer choices

On January 1, 2006, the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare prescription drug benefit as directed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The CMS undertook an unprecedented outreach and education campaign to maximize enrollment. Through a multi-pronged strategy for educating and enrolling people in the new drug benefit, which included a massive grassroots education effort, more than 38 million beneficiaries had drug coverage as of June 2006. In addition, the broad participation of beneficiaries with relatively low drug cost, coupled with the overwhelming popularity of plans with low premiums and generally slower growth in drug costs, has lowered projected costs for Medicare.

The Administration on Aging (AoA) collaborated with the CMS to help the elderly learn about and enroll in the prescription drug coverage program. AoA utilized the infrastructure of the National Aging Services Network to provide specialized information, technical assistance, outreach, and education to beneficiaries, with a particular emphasis on reaching out to limited-English speaking and hard-to-reach populations.

The Indian Health Service (IHS) healthcare delivery sites successfully facilitated the enrollment of 18,100 Medicare-eligible patients in the prescription drug coverage program. IHS collaborated with the Centers for Medicare & Medicaid Services to provide outreach and education in tribal communities with special emphasis on the new drug benefits. Expanded enrollment of American Indians and Alaska Natives will help provide greater prescription drug coverage to all people with Medicare.

The CMS is implementing the provisions of the Deficit Reduction Act of 2005, which gives states the tools to modernize their Medicaid programs. States now have new options to create programs that are more aligned with today's Medicaid populations and the healthcare environment. CMS is planning to implement the Medicaid Integrity Program to contract with eligible entities to conduct reviews, audits, and identification and recovery of overpayments, as well as provide education. This effort includes national expansion of the Medicare-Medicaid Data Matching program to better coordinate Medicare and Medicaid program integrity. The Medicare-Medicaid Data Matching program has led to cost avoidances, savings, recoveries, investigations, and law enforcement referrals.

Through the Health Resources and Services Administration's (HRSA's) Ryan White CARE Act's State AIDS Drug Assistance program, more than 131,800 individuals received essential Human Immunodeficiency Virus (HIV)/(AIDS) medications during at least one quarter of the year in FY 2005.

The Indian Health Service's (IHS) Telehealth program exemplifies IHS' commitment to enhanced access to care, healthcare quality, and novel training in a cost-efficient and sustainable model. The program offers opportunities for improving access to care because many Indian health facilities have limited access to specialist care. The term "telemedicine" refers to the remote delivery of direct clinical care via advanced information technologies; "telehealth" includes telemedicine as well as the use of advanced technologies for distance learning, program planning, and public health. Telehealth offers tools to support a culture of clinical quality in healthcare service delivery. Indian health telehealth partnerships include Federal agency collaborations, state and university programs, and other special projects. One example is the IHS Joslin Vision Network (tele-ophthalmology), which enhances annual retinal surveillance opportunities for patients with diabetes via a standardized image acquisition and interpretation methodology developed by the Harvard-affiliated Joslin Diabetes Center. Timely diagnostic interpretation of retinal images and management recommendations are provided to Indian health facilities by the IHS Joslin Vision Network National Reading Center in Phoenix, Arizona. To date, more than 13,807 examinations have been performed.

In August 2004, the Substance Abuse and Mental Health Services Administration (SAMHSA) began its Access to Recovery Initiative, which centers on a voucher-based payment system for a variety of clinical and recovery services. The use of vouchers strongly supports client choice. The program also seeks to expand the network of providers to include faith-based and community organizations. Fifteen grants were awarded to 14 states and one tribal organization with the goal of expanding client choice, improving access to clinical treatment and recovery support services, and increasing substance abuse treatment capacity. By the end of the 3-year grant program, SAMHSA expects that at least 125,000 clients will have received clinical treatment and/or recovery support services funded with Access to Recovery vouchers.

Strategic Goal 4. Enhance the capacity and productivity of the Nation's health science research enterprise

The Food and Drug Administration's Critical Path Initiative identifies and prioritizes the most pressing medical product development problems and the greatest opportunities for rapid improvement in public health benefits. Its primary purpose is to ensure that basic scientific discoveries translate more rapidly into new and better medical treatments by creating new tools to find answers about how the safety and effectiveness of new medical products can be demonstrated in faster timeframes with more certainty, at lower costs, and with better information.

The National Institutes of Health (NIH) are supporting the creation of an Alaskan Native Stroke Registry to address the lack of information on the causes of stroke in Alaska Natives. This registry will provide critical information on the disparity in stroke mortality.

Investigators at the Washington Hospital Center, where NIH has established an acute stroke research and care center, found that cerebral micro-hemorrhages (visualized by magnetic resonance imaging or MRI) may be predictive of strokes in African-Americans. The NIH-funded Northern Manhattan Study of Stroke recently demonstrated that Hispanic populations with increased left ventricular mass in the heart have a greater risk of vascular problems, including stroke, than the general population. Researchers have recruited approximately 22,000 out of a projected 30,000 individuals for the NIH-funded Reasons for Geographic and Racial Differences in Stroke (REGARDS) study, an observational study that is exploring the relationships between race and stroke prevalence, incidence, and mortality in a region of the country with particularly high stroke mortality rates. This rapid progress represents a major achievement in clinical study recruitment of both minorities and non-minorities.

Three NIH-supported drug treatment interventions are being tested in community-based settings and have enrolled a total of 1,187 patients (187 more than targeted). The patients enrolled in the drug treatment interventions include a high percentage of women (48 percent), African Americans (33 percent), Hispanics (21 percent), and multi-racial persons (8 percent), who are frequently under-represented in drug and alcohol abuse research and are often underserved in drug and alcohol abuse treatment centers.

Strategic Goal 5. Improve the quality of healthcare services

The Agency for Healthcare Research and Quality (AHRQ) Data Development Portfolio has successfully implemented a Healthcare Cost and Utilization Project and quality indicators to improve the quality of care delivered in a hospital setting. Covenant Healthcare, a system in Milwaukee, Wisconsin, used quality indicators to measure the effectiveness of its Rapid Response Teams, which are trained to intervene early and aggressively when a patient begins showing signs of decline. Use of these teams resulted in a drop in the failure to rescue rate (an AHRQ patient safety indicator) where teams and measures have been in place for more than 12 months. Mortality rates dropped as well.

AHRQ Patient Safety Improvement Corps, a partnership with the Department of Veterans Affairs, trained a team in every state (except Louisiana, which could not participate due to Hurricane Katrina) to improve patient safety by: (1) providing the knowledge and skills to conduct effective investigations of reports of medical errors; (2) preparing meaningful reports on findings; (3) developing and implementing sustainable system interventions; (4) measuring and evaluating the impact of the safety intervention; and, (5) transforming effective safety interventions into standard clinical practice. To continue the Corps' outstanding success, AHRQ is working to extend the program to a fourth year.

Data quality improvement is one of the areas that the Indian healthcare system continues to focus on for increasing efficiency, effectiveness, and the quality of healthcare delivery. In FY 2006, IHS received the Nicholas E. Davies Award of Excellence from the Healthcare Information and Management Systems Society for its role as a national leader in information technology and management systems such as the IHS Clinical Reporting System. This system is designed for national reporting and local and regional tracking of clinical performance indicators, such as assessment, care, and control of diabetes; immunization; and treatment of cardiovascular disease. The system intends to eliminate manual chart audits for evaluating and reporting clinical indicators for local performance improvement initiatives and for national agency reporting to Congress. The Clinical Reporting System produces reports on demand from local databases for one or more of 50 clinical topics, comprised of 349 individual indicators. Reports also compare the site's performance in the current report year to the previous year and to a user-defined baseline year. Users also can request patient lists for each of the measures, displaying patients who do and do not meet the indicator criteria. Local health facilities can run reports for individual or all indicators as often as needed and can use the system to transmit national-level data to their regional offices for quarterly reporting. The IHS regional offices can use Clinical Reporting System to produce an aggregated area report for national-level data.

SAMHSA initiated expansion of its National Registry of Evidence-Based Programs and Practices to include interventions to prevent and/or treat mental and substance use disorders. The registry's precursor identified interventions with demonstrated success in preventing or reducing substance use and other related high-risk behaviors that had been tested in communities, schools, social service organizations, and workplaces across America. SAMHSA developed the current expansion with input from public comments solicited through a Federal Register notice in August 2005. The resulting system, described in a March 2006 Federal Register notice, will be available to the public through a new website in early 2007.

Strategic Goal 6. Improve the economic and social well-being of individuals, families, and communities, especially those most in need

AoA helped seniors remain in their homes and communities by providing a variety of supportive, nutrition, and caregiver services in FY 2004, including approximately 36 million rides to doctors offices, grocery stores, and other critical daily activities; 249 million congregate and home-delivered meals; 13.5 million information contacts on caregiver program and service; and 21 million hours of in-home services such as personal care, homemaker, and chore services.

AoA continued to implement initiatives to create greater balance in long-term care, to improve access, and to emphasize prevention. Aging and Disability Resource Centers, funded in partnership with the CMS, provide consumers in 43 states with objective information about their care options and help states to streamline access and control costs. Evidence-based Disease Prevention projects assist aging service provider organizations in 12 communities to translate research findings into high-quality preventive interventions targeted to seniors.

The number of recipients for the Administration for Children and Families' (ACF's) Temporary Assistance to Needy Families' continued to decline through December 2005 as large numbers of people continue to move from welfare to work. In FY 2004, 30 percent of adult recipients were working (including employment, work experience, and community service), compared with less than 7 percent in 1992 and 11 percent in 1996. The recent welfare reform reauthorization and the interim final regulations published in June 2006 reinstate a more meaningful work participation rate so that even more families will achieve self-sufficiency. The new regulations further strengthen work participation requirements.

Strategic Goal 7. Improve the stability and healthy development of our Nation's children and youth

The ACF's Child Support Enforcement program established approximately 11.8 million child support orders from 15.9 million cases in FY 2004. This program collected $21.9 billion for child support in FY 2004, representing a 22 percent increase since FY 2000. More than 52,000 children were adopted from the child welfare system in FY 2004, according to preliminary data. This number may increase as additional adoptions for that year are reported. This represents a significant growth in the number of adoptions over the years, up from approximately 47,000 adoptions in FY 1999 and 31,000 adoptions in FY 1997. While the number of adoptions has held fairly constant in the most recent years, adoptions as a percentage of children in foster care increased from 8.4 percent in FY 1999 to 9.8 percent in FY 2004.

Overall, children in Head Start programs are gaining in word knowledge, emergent literacy, language skills, mathematics, and social skills. In addition, their parents are showing increased involvement in the children's education. One measure tracks improvements in learning readiness of infants, toddlers, and preschoolers during the 9-month school year. In FY 2004, Head Start increased the percentage of programs that achieved gains in word knowledge, letter identification of at least six letters, and at least four counting items. In FY 2005, 69 percent of Head Start teachers held an associate, bachelor, or advanced degree, or a degree in a field related to early childhood education, exceeding the Department's target of 65 percent. Finally, Head Start completed a third year of implementing a national child outcomes and assessment reporting system (National Reporting System) to strengthen program effectiveness; more than 400,000 4-year olds were assessed both in fall 2005 and spring 2006. Information on children's growth from this system will be used to assess technical assistance efforts with Head Start programs.

Strategic Goal 8. Achieve excellence in management practices

Unified Financial Management System—FY 2006 was an eventful year in the implementation of what will eventually be the world's largest financial management system—the HHS Unified Financial Management System (UFMS). The UFMS will eventually replace the Department's legacy systems with one modern accounting system having two components: 1) The Healthcare Integrated General Ledger Accounting System (HIGLAS) will support CMS and the Medicare contractors; and 2) UFMS Global will serve the rest of the Department. During FY 2006, the UFMS program met or exceeded its targets by remaining on schedule and on budget, an extraordinary accomplishment given its size and complexity.

By the end of FY 2006, CMS had successfully implemented HIGLAS at several Medicare contractor sites. Additionally, CDC and FDA migrated to UFMS. In October 2006, PSC will also be on-line adding numerous Departmental components to the system, including ACF, AoA, AHRQ, HRSA, and SAMHSA. NIH and IHS will be going online during FY 2007.

Property Management Information System—The PSC is successfully leading the Department-wide initiative to consolidate data from multiple legacy property systems into the Department's Property Management Information System. Asset records are in the new system for HRSA and CMS. Indian Health Service records are scheduled to be completed by the end of the fiscal year. The migration process with CDC is starting and FDA records are being analyzed for future migration. Also, the PSC is leading the implementation of the Enterprise Workflow Information Tracking System, a workflow application designed to track and monitor human resources performance and metrics. PSC led the successful implementation of an enterprise-wide pilot release of the system, and began the full implementation during the fourth quarter of FY 2006.

Implementation of Office of Management and Budget (OMB) Circular A-123, Appendix A—Revisions to OMB Circular A-123, "Management's Responsibility for Internal Control", require that Agencies conduct rigorous assessments of internal controls over

financial reporting beginning in FY 2006. During FY 2006, the Department developed and implemented a plan for conducting assessments of internal controls across the Department and completed the assessments according to plan. The Department is working to correct any internal control deficiencies identified in the assessments.

Program Performance Overview

HHS manages hundreds of programs that improve the health and well-being of the American public. The Office of the Secretary is responsible for providing overall policy guidance and direction to the components to help achieve the Department's strategic goals. The HHS Strategic Plan encompasses eight strategic goals which cover all HHS activities. The strategic goals, performance goals, and program results reflect the combined commitment and effort of HHS programs, and their state, local, Federal, Tribal and non-government partners. To gauge program effectiveness, HHS uses performance measures as a basis for comparing actual program results with established program performance goals, as required by the Government Performance and Results Act (GPRA). Given the complexity and vast number of programs and measures, HHS, along with OMB's concurrence, focuses on selected programs in this report to illustrate HHS' significant efforts and achievements during FY 2006.

The programs and corresponding measures in this report are presented according to the strategic goal each supports. The Department's FY 2006 Performance Scorecard, presented below, provides a summary of the Department's recent performance results. For FY 2006, the scorecard presents the performance targets, available results, and whether the measure was met, unmet or deferred. For the 35 performance measures highlighted in this report, HHS met 16 targets and deferred 18 targets [unable to report the necessary data until a specified date]. The remaining measure has two targets - one met and one deferred. The scorecard also presents available results for FY 2004 and FY 2005 to show the trend in how the programs have been performing. Analyses of these results and information on data quality can be found in Section II of this report.

FY 2006 Performance Scorecard

Programs	Measures	2004	2005	2006	
		Result	Result	Target	Result
Strategic Goal 1- Reduce the major threats to the health and well-being of Americans.					
1a - National Immunization Program (CDC)	Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 4 doses DTaP vaccine, 3 doses Hib vaccine, 1 dose MMR vaccine, 3 doses hepatitis B vaccine, 3 doses polio vaccine, 1 dose varicella vaccine, 4 doses PCV	DTaP 86%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 88% PCV: N/A	DTaP 86%; Hib 94%; MMR 92%; Hepatitis B 93%; Polio 92%; Varicella 88% PCV: N/A	90% coverage	**Deferred** 8/2007
1b -HIV/AIDS Prevention (CDC)	Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age.	2,606 in 25 states; 3,465 in 30 areas	11/2006	Overall: 2,420 reported cases in 30 areas	**Deferred** 11/2007
1b -HIV/AIDS Prevention (CDC)	Decrease the number of perinatally acquired AIDS cases from the 1998 base of 235 cases.	48	11/2006	<100 cases	**Deferred** 11/2007

FY 2006 Performance Scorecard					
Programs	Measures	2004	2005	2006	
		Result	Result	Target	Result
1c - Substance Abuse Prevention and Treatment Block Grant (SAMHSA)	Increase the number of clients served.	1,875,026	10/2007	1,983,490	**Deferred** 10/2008
Strategic Goal 2- Enhance the ability of the Nation's health care system to effectively respond to terrorism and other public health challenges.					
2a - Field Foods Program (FDA)	Perform prior notice import security reviews on food and animal feed line entries considered to be at risk for bioterrorism and/or to present the potential of a significant health risk.	33,111	86,187	45,000	89,034 **Met**
2b - National Bioterrorism Hospital Preparedness Program (HRSA)	Percent of awardees that have developed plans to address surge capacity.	89%	100%	100%	100% **Met**
2c - Terrorism Preparedness and Emergency Response Program (CDC)*	100 percent of state public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.	N/A	94% of state public health agencies have developed plans for at least one priority agent.	100%	**Deferred** 12/2006
Strategic Goal 3- Increase the percentage of the Nation's children's and adults who have access to regular health care services and expand consumer choices.					
3a - Health Centers Program (HRSA)	Increase the number of uninsured and underserved persons served by health centers.	13.1 M	14.1 M	14.62 M*	**Deferred** 8/2007
3a - Health Centers Program (HRSA)	Continue to assure access to preventive and primary care for racial/ethnic minorities.	63.5% 8.34 M	63.6% 8.99 M	64% 9.35 M	**Deferred** 8/2007
3a - Health Centers Program (HRSA)	Increase the infrastructure of the health center program to support an increase in utilization via: total new or expanded sites.	129	158	121	122 **Met**
3b Ryan White CARE Act program (HRSA)	Increase by 2% annually, the number of persons who learn their serostatus from Ryan White CARE Act programs.	553,569	02/2007	2% over FY 2005	**Deferred** 2/2008

FY 2006 Performance Scorecard					
Programs	Measures	2004	2005	2006	
		Result	Result	Target	Result
3c - National Diabetes Program (IHS)	Increase the proportion of patients with diagnosed diabetes with ideal glycemic control (A1c<7.0).	Diabetes Audit: 34% Clinical Reporting System (CRS): 27%	Diabetes Audit: 36% CRS: 30%	Diabetes Audit: 36 CRS: 32%*	Diabetes Audit: **Deferred** 11/2006 CRS: 31% **Not Met**
3d - Children's Mental Health Services (SAMHSA)	Improve children's outcomes and systems outcomes: Increase percentage of participants with no law enforcement contacts at 6 months.[1]	67.6%	68.3%	68%	**Deferred** 12/2006
3e - Medicaid/ SCHIP (CMS)	Decrease the number of uninsured children by working with states to enroll children in SCHIP and Medicaid.	+2,300,000	+1,100,000 or 3.1%	Increase the number of children who are enrolled in regular Medicaid or SCHIP by 3 percent, or approximately 1,000,000 over the previous year.	**Deferred** 3/2007
3e - Medicaid/ SCHIP (CMS)	Improve health care quality across Medicaid.	Updated timeline to implement recommendations; Identified strategy to improve health delivery/quality; implement recommendations.	Refined strategy; collected 2002 data from 10 states; provide technical assistance.	Collect, on a voluntary basis, 2003 performance measurement data from a minimum of 13 States, and continue to provide technical assistance to States to improve performance measurement calculation and reporting.	Collected data from 13 States and provided technical assistance. **Met**
3e - Medicaid/ SCHIP (CMS)	Improve health care quality across SCHIP.	Refined data submission; produced standard measures; collected 2003 baseline data.	Collected core performance measures; used new automated template to evaluate data; provided technical assistance to States.	Improve reporting by States on core performance measures in order to have at least 25% of States reporting four core performance measures in FY 2005 Annual Report.	At least 25% of States reported four core performance measures in FY 2005 report. **Met**
3f - Medicare (CMS)	Implement the new Medicare Prescription Drug Benefit.				
	Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006.	N/A	47%	49.4%*	67% **Met**

FY 2006 Performance Scorecard					
Programs	Measures	2004	2005	2006	
		Result	Result	Target	Result
	Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan.	N/A	50%	52.5%	69% **Met**
	Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs.	N/A	27%	28.4%	50% **Met**
	Implement a Part D Claims Data System, oversight system, and contractor management system.	N/A	N/A	Implement a Part D Claims Data System, oversight system, and contractor management system.	Implemented a Claims Data System; Improved oversight reduced call center wait times; and implemented Contractor Management System. **Met**
3f - Medicare (CMS)	Improve satisfaction of Medicare beneficiaries with health care services they receive.	Monitor annual data toward 5-year target.	Medicare Advantage Access to Care: 90% Medicare Advantage Specialist: 93%	Develop MMA measures to include in the Medicare Consumer Assessment of Healthcare Providers and Systems survey.*	Survey field tested. **Met**
3g - Medicare Quality Improvement Organizations (CMS)	Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal.	Influenza: 72.8% Pneumococcal: 67.4%	12/2006 12/2006	Influenza vaccination for nursing home subpopulation: 74% National pneumococcal vaccination: 69%*	**Deferred** 12/2007 **Deferred** 12/2007
Strategic Goal 4- Enhance the capacity and productivity of the Nation's health science research enterprise.					
4a - Culturally Appropriate Stroke Prevention Programs for Minority Communities (NIH)	By 2010, identify culturally appropriate, effective stroke prevention programs for nationwide implementation in minority communities.	Established acute stroke care center serving a minority community in Washington, DC metropolitan area.	Established research infrastructure and advisory committees, and hired director for Stroke Prevention and Intervention Research Program.	Establish the infrastructure for a pilot Alaska Native Stroke registry that will facilitate identifying risk factors and strategies to improve stroke prevention and quality of stroke care provided to Alaska Natives.	Established Alaskan Native Stroke Registry, began enrolling patients. **Met**
4b - Treatment for Drug Abuse in Community Settings (NIH)	By 2008, develop and test two new evidence-based treatment approaches for drug abuse in community settings.	Three treatments have been adapted for community-based settings.	The Clinical Trials Network has trained 184 providers (94 more than planned) in Brief Strategy Family Therapy, Motivational Enhancement Treatment, and Seeking Safety, which are being tested in community settings.	Recruitment will be completed of approximately 1000 patients from specialized populations to test the efficacy of community-based treatments.	**Deferred** 2/2007

FY 2006 Performance Scorecard					
Programs	Measures	2004	2005	2006	
		Result	Result	Target	Result
4c-Knowledge Base on Chemical Effects in Biological Systems (CEBS) (NIH)	By 2012, develop a knowledge base on chemical effects in biological systems using a systems toxicology or toxicogenomics approach.	CEBS now has a data portal that loads toxicology data. CEBS can import, export, and link molecular expression data to toxicology/ pathology fields.	CEBS versions 1.5 and 1.6 have been made available to the public. These programs provide simple query download capability of global molecular expression and toxicology/pathology data on a select number of studies of chemicals found in the environment and drugs that have an effect on biological systems.	Enhance the CEBS to allow the capture and integration of transcriptomics, proteomics, and toxicologic data for the same compound.	CEBS version 2.0.7 was released and is the first public repository designed to capture, and fully integrate with 'omics data, toxicological, histopathologi-cal and other biological measures. **Met**
Strategic Goal 5- Improve the quality of health care services.					
5a - Medical Product Surveillance Network (MedSun) (FDA)	Expand actively participating sites in MedSun Network to 71 percent.	299 facilities	354 facilities	71%	86% **Met**
5b - Human Drugs Program (FDA)	Percentage of Priority New Drug Applications reviewed within six months.	96%	10/2006	90%	**Deferred** 10/2007
5c - Health IT (AHRQ)	By 2014, most Americans will have access to and utilize a Personal Electronic Health Record (EHR).	N/A	AHRQ funded a phased EHR improvement that implemented interoperability with other public/private providers.	AHRQ will partner with one major HHS Operating Division to expand the capabilities of the EHR.	Pursuant to American Health Information Community (AHIC) May 2006 recommendat-ion, AHRQ is collaborating with CMS to support faster development of improved Personal Health Records (PHR). **Met**
				The core capabilities and function of the (PHR) will be delineated.	AHRQ is participating fully in the AHIC Consumer Empowerment Workgroup activities to establish the core capabilities of PHRs 2006 is defining key elements of a PHR. **Met**
5d - Prevention Portfolio (AHRQ) 5d - Prevention Portfolio (AHRQ)	Increase the quality and quantity of preventive care delivered in the clinical setting especially focusing on priority populations.	Expert opinions regarding best practices for delivering clinical preventive services obtained through stakeholder meetings and focus groups. Developed Train the Trainer program.	**Cervical Cancer**: % of women (18+) who report having had a Papanicolau smear within the past 3 years – 81.3% **Colorectal Cancer:** - % of men & women (50+) report they ever had a flexible sigmoidoscopy/colonoscopy – 38.9% - % of men & women (50+) who report they had a fecal occult blood test (FOBT) within the past 2 years – 33% **Cardiovascular Disease:** - % of people (18+) who have had blood pressure measured within preceding	Establish baseline for reach of evidence-based preventive services through use of products and tools.	1) Views and downloads of electronic content: - USPSTF recommendations: 4,242,074 -General Preventive services: 1,621,848 - Preventive Services Selector tool: 13,496 -National Guideline Clearinghouse related to USPSTF recommendations: 359,634 2.) Dissemination of published products: - 2005 Clinical

FY 2006 Performance Scorecard					
Programs	Measures	2004	2005	2006	
		Result	Result	Target	Result
			2 years and can state whether their blood pressure is normal or high – 90.1% - % of adults (18+) receiving cholesterol measurement within 5 years – 67.0% **Cardiovascular Disease and Cancer:** - % of smokers receiving advice to quit smoking – 60.9%		Guide: 11,021 -Consumer products: 352,216 -Adult Preventive Care Timeline: 1,819 -Journal publications: Pediatrics, 2 publications, circulation 63,000 Annals of Internal Medicine, 1 publication, circulation 92,756 **Met**
	Improve the timeliness and responsive-ness to the United States Preventive Services Task Force.		**9 recommendations** released **78% current** within National Guideline Clearinghouse standards (reviewed within 5 years) **100% of recommendations** related to Institute of Medicine priority areas for preventive care current within National Guideline Clearinghouse standards. **Develope**d new topic criteria, submission, review, and prioritization processes with new USPSTF topic prioritization workgroup.	Decrease the median time from topic assignment to recommendation release.	Four topics released to date in FY 2006, time from assignment to release ranged from 14 to 30 months, median time 25 months. **Met**
5d - Prevention Portfolio (AHRQ)	Increase the number of partnerships that will adopt and promote evidence-based clinical prevention.	Produced fact sheets Partnered with professional societies and advocacy groups.	**Federal partners** – 8 **Non-Federal partners** - 10 Primary Care Organizations - 2 Health Care Delivery Organizations - 1 Consumer Organization - 3 Employer Organizations - Other organizations – 3	Increase the number of partnerships adopting evidence-based clinical prevention by 5%.	**Federal partners** – 10 **Non-Federal partners** - 10 Primary Care Orgs - 2 Health Care Insurance Industry - 2 Consumer Organization - 3 Employer Organizations - 6 Other organizations **Met**
Strategic Goal 6- Improve the economic and social well-being of individuals, families, and communities, especially those in most need.					
6a - Temporary Assistance for Needy Families (ACF)	Increase the percentage of adult TANF recipients/former recipients employed in one quarter that were still employed in the next two consecutive quarters.	59%	64.8%	61%*	**Deferred** 10/2007
6b - Aging Services Program (AoA)	Increase the number of severely disabled clients who receive selected home and community-based services.	293,500	313,362	322,522 (base + 15%)	**Deferred** 2/2007

FY 2006 Performance Scorecard					
Programs	Measures	2004	2005	2006	
		Result	Result	Target	Result
Strategic Goal 7- Improve the stability and health development of our Nation's children and youth.					
7a - Child Support Enforcement (ACF)	Increase the Title IV-D collection rate (collections on current support/current support owed).	59%	11/2006	62%	**Deferred** 11/2007
7b - Child Welfare (ACF)	Increase the adoption rate. [2]	52,000/ 10%	51,000/ 9.86%	9.85%	**Deferred** 10/2007
7c - Head Start (ACF)	Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.	81%	81%	80%	**81% Met**
Strategic Goal 8: Achieve Excellence in Management Practices.					
8a - Medicare Integrity Program (CMS)	Reduce the Percentage of Improper Payments Made Under the Medicare Fee-For-Service Program.	10.1 %	5.2 %	5.1 %	4.4% **Met**
8b - Medicaid and the State Children's Health Insurance Program (SCHIP) (CMS)	Estimate the payment error rate in the Medicaid and SCHIP.	N/A	N/A	Begin to implement error measurement for Medicaid fee-for-service in 17 States.	**Deferred** 9/2007
8c - Health Care Fraud and Abuse Control Program (HCFAC) (OIG)	Return on Investment (ROI)	$10.5:1	$11.6:1	$11.9:1	$12.9:1 **Met**

Unmet Performance Target

HHS met the targets for all but one measure for which FY 2006 data was available. Measure 3c, from National Diabetes Program of the Indian Health Service, aims to increase the proportion of American Indian and Alaska Native patients demonstrating ideal glycemic control to 32 percent in FY 2006, as measured by the Clinical Reporting System (CRS). Although IHS did not meet the glycemic control indicator based on the CRS data, it did achieve a rate of 31 percent, a one percentage point improvement over the FY 2005 level. Meeting this target requires costly drug treatment and monitoring as well as patient compliance. Because this rate reflects patient health status rather than the provision of a specific procedure or screening, it is more costly and difficult to affect improvement within a short time frame. However, over a longer period of time, the agency has sustained improvement, increasing the proportion of patients in ideal control by six percentage point since 2002.

Program Performance and Measurement Challenges

External Factors Affecting Performance: HHS continuously works to improve its performance across all of its programs. External factors and influences beyond HHS' control affect achievement of the Department's strategic goals and objectives. These factors introduce risks and uncertainties into the Department's planning environment and pose challenges that may be difficult to overcome. State and local governments are major partners of the Department, both in determining health and social service funding levels and program implementation Even during the best of economic times, the competition between health and social services, and other priorities, for limited public funds affects the achievement of HHS' long-term goals. Similarly, social trends, reflecting individuals' daily decisions, have significant influence on the overall health and welfare of the Nation.

Measurement Challenges: For a large, diverse organization like HHS that works to accomplish its mission indirectly—in partnership with and by assisting others—performance measurement is challenging. HHS programs collect data through several entities including state and local governments, nonprofit and faith-based organizations, and universities and research institutions. Several HHS programs rely on third parties for data collection and reporting, which can result in performance data availability lags. In addition, not all HHS performance data are collected or available annually. The Department seeks continuous improvement in its selection of goals and in policies and procedures for collecting and reporting program performance data so that managers and other decision makers can rely on them. However, each program must consider the costs and benefits of gathering and managing such information. Changes take time to implement and reporting requirements can impose considerable burdens on staff, partners, beneficiaries and regulated entities.

Data Collection, Review and Validity

HHS has a multi-level approach to assuring the quality of performance information reported in the PAR. The majority of measures use data either from statistical surveys or grantee reports. For grantee reports, the Department has assigned to the components the task of ensuring the reliability of information received from grantees. The Department expects components to maintain the validity of surveys they conduct. (HHS also has a Data Council that is responsible for overall review of the quality and usefulness of data from HHS surveys.) Within the components, both the central offices and the program offices review data for completeness and consistency with past data and changes that could be expected to affect measured outcomes and outputs. In the HHS Office of Budget, staff review and update performance data submitted by HHS components. The FY 2007 Performance Budget and the FY 2006 HHS Annual Plan are used to reference and review the data submitted by the components to ensure consistency and completeness in reporting. Analysts in the Office of Budget complete a checklist to make sure that reporting is consistent throughout these documents and the supporting documentation such as component websites display accurate and current data.

President's Management Agenda

The President's Management Agenda articulates the Administration's strategy "for improving the management and performance of government." It established five government-wide and nine program-specific initiatives. Agencies develop and implement action plans to achieve goals related to these initiatives.

Through the use of scorecards, agencies are publicly held accountable for achieving established goals. The scorecards, released quarterly, employ a simple grading system of green for success, yellow for mixed results, and red for unsatisfactory to measure status and progress toward attainment of goals. (For more information about the President's Management Agenda, visit www.results.gov.)

HHS participates in five government-wide and five program-specific initiatives. It consistently has been a high performer on the scorecard. For FY 2006, the Department finished the fiscal year with green progress ratings for nine of the ten initiatives it is scored on, signifying its commitment to achieving its goals. The Department's scorecard as of September 30, 2006 and accomplishments during FY 2006 are presented below.

Status	Progress	Initiative	Fiscal Year 2006 Accomplishments
G	G	**Strategic Management of Human Capital** To build, sustain, and effectively deploy a skilled, knowledgeable, diverse, and high-performing workforce to meet current an emerging needs, and align strategies with organizational mission, vision, core values, goals, and objectives.	• Revised HHS Comprehensive human capital plan. • Implemented one Performance Management Appraisal Program for all non-Senior Executive Service and bargaining unit employees throughout the Department. • Developed and implemented performance appraisal plans that adhere to merit system principles. • Completed a beta site for the new Performance Management Appraisal Program. • Met competency gap targets for grants management. • Reduced hiring timelines. • Developed an Accountability and Implementation Policy and Program. • Met leadership hiring targets for Senior Executive Service and Emerging Leaders. • Identified and validated 10 core competencies that all HHS employees will need to possess in upcoming years.
G	G	**Competitive Sourcing** To achieve efficient and effective competition between public and private sources by simplifying and improving the procedures for evaluating public and private sources, better publicizing the activities subject to competition, and ensuring senior-level agency attention to the promotion of competition.	• Reported an estimated $365 million of competitive sourcing savings based on competitive sourcing studies completed in FY 2003 - FY 2005 in its Section 647 Report to Congress. These studies estimated savings, when fully implemented over the next several fiscal years, will provide greater benefit to HHS programs and the American taxpayer. • Completed independent analyses that successfully validated savings for a standard competition at NIH and a restructuring effort at CDC. • Followed the Office of Management and Budget, Office of Federal Procurement Policy, and Office of Personnel Management's lead by developing an all-day symposium to enhance communications between the disciplines entitled "Partnerships for the American Workforce." The symposium, developed by HHS competitive sourcing and human resources, was well received and featured a number of guest speakers discussing pertinent staff issues.
R	G	**Improved Financial Performance** To ensure financial systems produce accurate and timely information to support operating, budget, and policy decisions by improving timeliness, enhancing usefulness, and ensuring reliability by obtaining and sustaining clean audit opinions.	• Fully implemented the Unified Financial Management System (UFMS) at the CDC and the FDA in 2005, and implementation was begun in 2006 for the Program Support Center, which provides financial services to HHS components. • Delivered federally mandated reports (i.e., five principal financial statements) via UFMS for Program Support Center using Oracle's reporting tool, Discoverer. • Completed Indian Health Service specific requirements for UFMS. • Completed UFMS interface to E-Travel for FDA and CDC. • Added new Grants functionality to UFMS for FDA and CDC. • Consolidated infrastructure platform for UFMS and NBS at National Institutes of Health Center for Information Technology. • Met quarterly financial statement reporting requirements. • Implemented revised Office of Management and Budget Circular A-123, *Management's Responsibility for Internal Controls*: strengthened controls. • Presented the Statement of Social Insurance as a principal financial statement for the first time.

Status	Progress	Initiative	Fiscal Year 2006 Accomplishments
R	Y	**Expanded Electronic Government** To leverage the use of information technology to significantly improve the government's ability to serve citizens, reduce the costs of delivering those services, and ensure electronic transactions are private and secure.	• Executed all required e-Gov/Line of Business Memoranda of Understanding and transferred funds. • Completed and issued Capital Planning and Investment Control and Earned Value Management Policy and Procedures documents and Governance Charters. • Developed draft standard Work Breakdown Structure template. • More than 90 percent of major information technology investments were within 10 percent of cost, schedule, and performance objectives. • Conducted review of Independent Baseline Validations, Corrective Action Plans, and Re-Baseline Requests of Major, Tier-One investments. • Aligned the HHS components' Federal Information Security Management Act Plan of Action and Milestones process with Secure One HHS program and reported alignment metrics. • Fully certified and accredited all Department systems reported via the Federal Information Security Management Act. • Maintained tested contingency plans for all Federal Information Security Management Act systems. • Finalized security configuration policy and ensured all applicable systems were maintained in accordance with this policy. • Conducted and posted Privacy Impact Assessments for at least 90 percent of applicable systems. • Developed and published system of records notices for at least 90 percent of applicable systems.
Y	G	**Budget and Performance Integration** To use performance information to inform funding and management decisions and to improve program performance and create a more effective and efficient Federal government.	• Submitted integrated performance budgets to Congress. • Completed and submitted performance sections for the FY 2005 Performance and Accountability Report. • Increased the percent of Program Assessment Rating Tool (PART) programs with an efficiency measure from 50 percent to over 90 percent. • Demonstrated that four programs can calculate marginal cost, using HHS' marginal cost methodology. • Identified cost savings associated with PART program efficiency measures. • Prepared Results Not Demonstrated PART programs for reassessment. • Developed and implemented PART follow-up actions in PARTWeb.
R	G	**Eliminating Improper Payments** To eliminate improper payments in government programs.	• Reduced the Medicare FY 2005 paid claims error rate of 5.2 percent, or $12.1 billion, in gross improper payments to 4.4 percent, or $ 10.8 billion, in FY 2006. • Reported a Head Start improper payment rate of 3.1 percent or $210 million. • Finalized the Foster Care FY 2005 error rate. Reduced the FY 2004 error rate of 10.33 percent, or $186 million to 8.6 percent, or $152 million in FY 2005. Reported an FY 2006 error rate of 7.86 percent of $134 million. • Ensured states participating in the Payment Error Rate Measurement pilot determined Medicaid payment error rates. Also, HHS finalized a plan for estimating an improper payment error rate in the Medicaid program. • Ensured states participating in the Payment Error Rate Measurement pilot determined SCHIP payment error rates. Also, HHS finalized a plan for estimating an improper payment error rate in SCHIP. • Developed a plan to measure improper payments in TANF. • Initiated the identification of a methodology for estimating improper payments for various Child Care activities. • Engaged in recovery auditing activities in which an insignificant amount of improper payments was identified. • Completed FY 2006 program risk assessments.
Y	G	**Broadening Health Insurance Coverage through State Initiatives** To increase the number of individuals with access to affordable health insurance by increasing state flexibility and encouraging public-private partnerships to provide health insurance to low-income individuals while ensuring prudent management of Federal Medicaid and State Children's Health Insurance Program funds.	• Estimated that CMS Health Insurance Flexibility and Accountability (HIFA) demonstrations, if fully implemented, could result in as many as 954,920 new enrollees. • Approved the CMS Arkansas HIFA demonstration. • Awarded a contract to the University of Minnesota and its partners to complete an evaluation of the relationship between the demonstrations and the number and rate of uninsured in states that implement the HIFA demonstrations.
G	G	**Faith-Based and Community Initiative** To create an environment within the Department that welcomes the participation of faith-based and	• Contributed to a report released by the White House Office of Faith-Based and Community Initiatives on grant awards made to faith-based organizations in FY 2005. The report noted that HHS awarded $780 million through 884 grants to faith-based organizations in FY 2005. This was a 64 percent increase in the amount of funding awarded to faith-based organizations from 2002 and an 83 percent increase in the number of grants awarded over the same period.

Status	Progress	Initiative	Fiscal Year 2006 Accomplishments
		community organizations as valued and essential partners in helping Americans in need.	• Participated in regional conferences on the Faith-Based and Community Initiative and has maintained web resources and information to help organizations increase their capacity and improve grant applications. • Worked with other Federal agencies to develop guidance for state and local administrators of Federal funds on the implementation of Charitable Choice and Equal Treatment regulations. This effort will level the playing field for grassroots organizations at all levels of government. • Implemented pilot programs, including Compassion Capital Fund, Mentoring Children of Prisoners, and Access to Recovery Program. HHS has started the evaluation process on HHS pilot programs and results are being demonstrated and documented by these programs.
Y	G	**Real Property Asset Management** To improve asset management and right-size inventory.	• Implemented an Office of Management and Budget-approved Real Property Asset Management Plan. • Implemented the HHS Automated Real Property Inventory System consistent with Federal Real Property Council standards, provided required data at the constructed asset level to the government-wide database. • Implemented Council-required (facility cost, utilization, condition and mission dependency) and HHS-specific performance measures (construction) and advised use data analyzed in daily real property management decision-making. All projects meet scope, budget, and schedule as stated on the HHS Facility Project Approval Agreement. • Published the HHS Real Property Human Capital Plan and distributed to each HHS component for implementation.
G	G	**Research and Development Investment Criteria** To develop objective investment criteria for Federal research and development projects that will better focus the government's research programs on performance.	• Used research and development criteria to develop replacement Government Performance and Results Act performance goals. • Achieved a PART rating of "effective" for the NIH Intramural Research Program and for the NIH Building & Facilities Program. • Continued to incorporate research and development investment criteria of quality, relevance and performance into the peer-review process.

FY 2007 Action Plan

For the coming year, the Department established the following goals to further its progress relating to the President's Management Agenda initiatives:

Strategic Management of Human Capital

- Fully implement the Performance Management Appraisal Program throughout the Department.
- Fully close the competency gap in human resources management.
- Identify key Departmental focus areas resulting from the Federal Human Capital Survey and develop action plans to address these areas.

Competitive Sourcing

- Utilize a combination of standard studies, streamlined studies, and restructuring efforts to review an estimated 1,000 commercial positions in FY 2007.
- Encourage increased private sector participation.
- Review completed studies and take action as necessary, in order to determine competitive sourcing study requirements are met.
- Run consistent competitions to encourage increased private sector participation.
- Review competitions performed to determine that performance standards are met and take necessary corrective actions.

Improved Financial Performance

- Develop a comprehensive "Green Plan" for meeting the President's Management Agenda standards for getting to green.
- Complete FY 2007 assessments of internal controls as required under OMB Circular A-123, Appendix A.
- Improve internal controls over financial reporting by correcting deficiencies identified in OMB Circular A-123, Appendix A assessments.
- Fully implement the Unified Financial Management System at PSC in October 2006, implement core financial management systems at IHS, and implement SUNFLOWER, PRISM and iProcurement systems at NIH.

Expanded Electronic Government

- Demonstrate use of Earned Value Management variance data in Information Technology (IT) management decision processes, including capital planning and budgeting, and integrate IT portfolio and earned value management tools.
- Formalize the process for the Capital Planning and Investment Control/budget formulation integration.
- Secure all systems through the proper application of the certification and accreditation methodology.
- Retain a tested IT contingency plan for each appropriate system.
- Ensure that at least 98 percent of employees and contractors receive general security awareness training.
- Ensure that at least 90 percent of employees and contractors with significant security responsibilities receive appropriate role-based training.
- Ensure that at least 90 percent of applicable systems have a Privacy Impact Assessment that is publicly posted.
- Ensure that at least 90 percent of systems with personally identifiable information have appropriate systems of records developed and published notices.

Budget and Performance Integration

- Meet the green standard for documenting that senior management meetings use performance and financial information to improve program performance and efficiency.
- Decrease the percentage of PART programs rated Results Not Demonstrated.
- Ensure all completed PART programs have an efficiency measure with baseline data and targets.

Eliminating Improper Payments

- Identify and implement appropriate corrective action to further reduce the FY 2006 reported payment errors rates for Medicare, Foster Care and Head Start.
- Implement methodology to estimate error rates for Medicaid, SCHIP, and TANF.
- Continue to develop a methodology for estimating payment errors in Child Care.
- Identify vulnerabilities that continue to improper payments in the Medicare Advantage and Medicare Prescription Drug Benefit programs.
- Continue HHS recovery auditing activities.

Broadening Health Insurance Coverage

- Implement the evaluation to determine the relationship between the Health Information Flexibility and Accountability (HIFA) demonstrations and the number and rate of uninsured in states that implement the HIFA demonstrations.
- Continue to work with states to expand coverage and provide state flexibility through available waivers under the Medicaid Plan.

Faith-Based and Community Initiative

- Report on the participation of faith-based and community organizations in select grant programs for FY 2006. This report will include data on the amount granted to organizations and an analysis of the applicants to select grant programs.
- Implement opportunities for faith-based and community organizations to access federal, state, and local funds.
- Continue to work with Office of General Counsel and operating components to provide regulatory training for staff throughout the Department, new grantees, and outside organizations.
- Continue to explore opportunities to implement individual choice in select HHS programs.
- Continue evaluation of pilot programs to showcase results achieved by grantees in pilot programs.

Real Property Asset Management

- Develop workplace competencies by delivering to at least 60 staff a facilities management course to better implement Executive Order 13327 and Departmental and component plans and policies, to result in cost avoidance savings, better recruitment, retention, and succession plans.
- Identify and initiate disposal of excess owned and leased underutilized and non-mission critical property.
- Implement a strategy to reduce annual operating costs by 5 percent by FY 2011 ($10-$12 million cost avoidance savings per year) by linking real property operating costs to the budget decision-making process for Real Property Asset Management.
- Implement a strategy to improve the average Condition Index of the Department's portfolio to 90 by FY 2016. The ultimate goal is for all facilities to achieve a minimum Condition Index of 90 to improve the Departmental staff health and productivity.
- Transmit a complete and accurate profile of the Department's Automated Real Property Inventory System that includes disposal activity data elements to the Government-wide Federal Real Property Profile.

Research and Development Investment Criteria

- Peer-review all NIH grants competitively based on quality, relevance and performance.
- Develop replacement Government Performance and Results Act goals for the FY 2009 Congressional Justification using the R&D investment criteria.

Analysis of Financial Statements and Stewardship Information

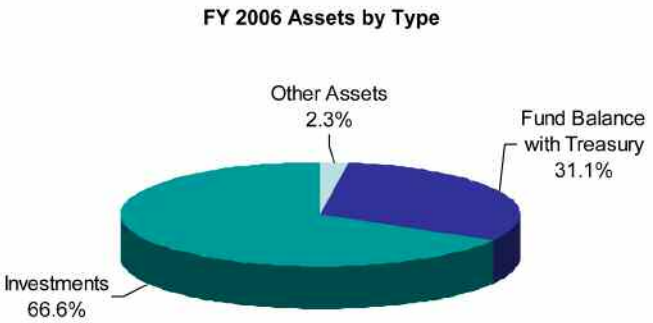
For the eighth consecutive year, HHS received an unqualified or "clean" audit opinion on its financial statements. These statements have been prepared from the Department's financial records using an accrual basis in conformity with accounting principles generally accepted in the United States and audited by the independent accounting firm of PricewaterhouseCoopers, LLP. Preparation and audit of these statements are required by the Chief Financial Officers (CFO) Act of 1990 and is part of the Department's goal to improve financial management and to produce accurate and reliable information that is useful in assessing performance and allocating resources.

Financial Condition

The Department's audited principal financial statements and notes are presented in Section III of this report. The following chart summarizes assets, liabilities, net position, and net cost of operations for FY 2005 and FY 2006 and increases/decreases from FY 2005.

FINANCIAL CONDITION *(Millions)*	FY 2006	FY 2005	Increase (Decrease)	% CHANGE
Total Assets	$ 513,909	$ 428,487	$ 85,422	19.9%
Total Liabilities	$ 78,425	$ 70,959	$ 7,466	10.5%
Net Position	$ 435,484	$ 357,528	$ 77,956	21.8%
Net Cost of Operations	$ 623,937	$ 581,320	$ 42,617	7.3%

Assets



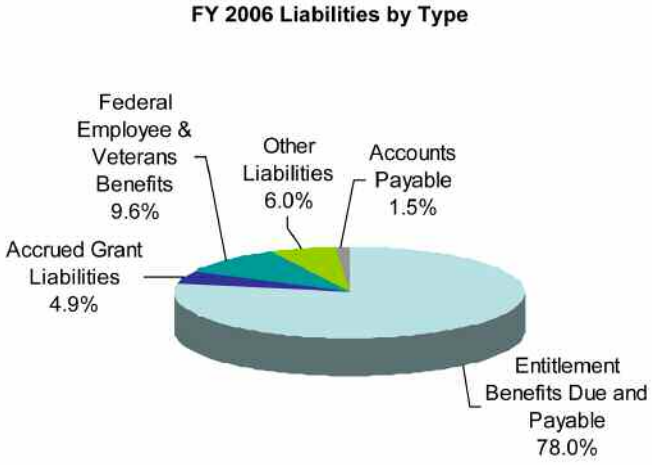
HHS assets were $513,909 million at the end of FY 2006. This represents an increase of $85,422 million, or 19.9 percent over the prior year's assets. This increase is largely attributable to increases of $60,283 million in Fund Balance with Treasury and $41,312 million in Net Investments. The increase in Fund Balance with Treasury resulted primarily from a $27,021 million increase in trust funds, which consisted of increases of $27,057 million in Hospital Insurance (HI) and Supplementary Medical Insurance (SMI), and a $36 million decrease in other trust funds. In addition, there was a $32,977 million increase in HHS appropriations. The Net Investments increase was largely related to growth in the Medicare trust funds for HI and SMI. Funds not currently needed to pay Medicare benefits and related expenses are held in the HI and SMI trust funds and invested in U.S. Treasury securities.

Fund Balance with Treasury and Net Investments together comprise 97.7 percent of total assets. Remaining assets consist of Accounts Receivable, Loans Receivable, Cash and Other Monetary Assets, Inventory and Related Property, General Property, Plant, and Equipment, and Other Assets, each less than 1 percent of total assets. An anticipated congressional appropriation of $14,272 million was reported in FY 2005 assets but was not reported in FY 2006, which accounts for a large share of the decrease from FY 2005–FY 2006.

ASSETS *(Millions)*	FY2006	FY 2005	Increase (Decrease)	% Change
Fund Balance with Treasury	$ 159,921	$ 99,638	$ 60,283	60.5%
Investments, Net	$ 341,976	$ 300,664	$ 41,312	13.7%
Other Assets	$ 12,012	$ 28,185	$ (16,173)	-57.4%
Total Assets	$ 513,909	$ 428,487	$ 85,422	19.9%

Liabilities

HHS liabilities were $78,425 million at the end of FY 2006. This represents an increase of $ 7,466 million, or 10.5 percent over the prior year's liabilities. Almost all of the entitlements represent benefits due and payable to the public from the Medicare and Medicaid insurance programs. Of the FY 2006 increase in entitlements, $7,425 million was attributed to the Medicare program. Entitlement Benefits and Federal Employee and Veterans Benefits account for 78.0 percent and 9.6 percent of total liabilities, respectively.



It is important to note that no liability has been recognized on HHS' balance sheet (nor were costs included in the Statement of Net Cost) for future payments to be made to current and future program participants beyond the existing Incurred but Not Reported Medicare claim amounts as of September 30, 2006. This is because Medicare is accounted for as a social insurance program rather than a pension program, consistent with Federal accounting standards.

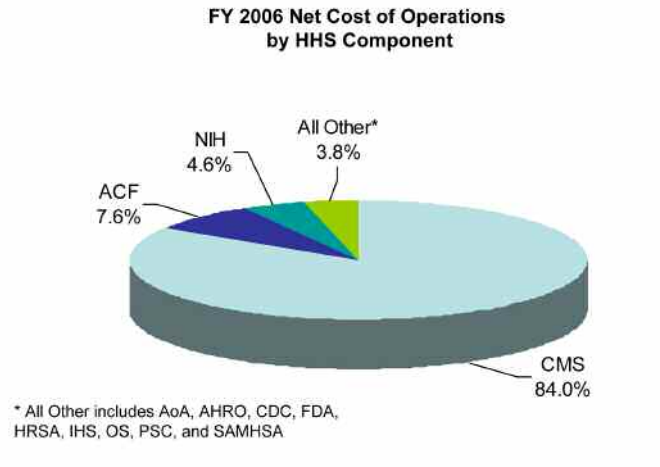
LIABILITIES *(Millions)*	FY2006	FY 2005	Increase (Decrease)	% Change
Accounts Payable	$ 1,182	$ 1,097	$ 85	7.8%
Entitlement Benefits Due and Payable	$ 61,164	$ 53,754	$ 7,410	13.8%
Accrued Grant Liabilities	$ 3,833	$ 3,783	$ 50	1.3%
Federal Employee & Veterans Benefits	$ 7,532	$ 7,183	$ 349	4.9%
Other Liabilities	$ 4,714	$ 5,142	$ -428	-8.3%
Total Liabilities	$ 78,425	$ 70,959	$ 7,466	10.5%

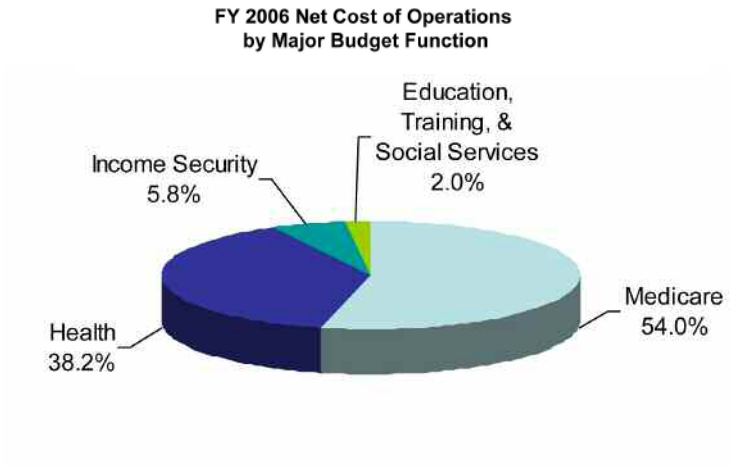
Ending Net Position

At the end of FY 2006, HHS' Net Position shown on the Consolidated Balance Sheet and the Consolidated Status of Changes to Net Position was $435,484 million, an increase of $77,956 million (21.8 percent) from the previous year. This was due to an increase of $34,809 million in cumulative results of operation and an increase of $43,147 mllion in unexpended appropriations. Net Position is the sum of cumulative net results of operation since inception and unexpended appropriations, those appropriations provided to HHS that remain unused at the end of the fiscal year.

Net Cost of Operations

HHS net costs of operations during FY 2006 was $623,937 million. This represents an increase of $42,617 million, or 7.3 percent over FY 2005 costs of more than $581,320 million. The Medicare budget function accounted for all of the $42,617 million total increase for FY 2006. HHS component gross cost for FY 2006 increased $54,492 million over FY 2005 and exchange revenues increased $11,875 million, largely due to an increase in Medicare premiums collected from beneficiaries. The largest share of increase in net costs is attributed to the Centers for Medicare & Medicaid Services, whose costs increased $40,753 million. The following two charts depict HHS' net cost of operations by HHS component and by Major Budget Function.





Budgetary Resources

The Combined Statement of Budgetary Resources provides information on how budgetary resources were made available and their status at the end of the year. Total resources of $952,823 million for FY 2006 were an increase of $158,981 million over FY 2005, a 20 percent increase. FY 2006 obligations of $884,903 million were $109,268 million over FY 2005 obligations, a 14.1 percent increase. Resources at year-end were $67,920 million of which $7,666 million was not available for expenditure. Total net outlays of $614,674 million, cash disbursed for the Department's obligations, increased $33,380 million (5.7 percent) over FY 2005 outlays. Outlays for Medicare and Medicaid combined were $49,819 million less than in FY 2005, while outlays for all other HHS programs in FY 2006 were $83,199 million more than the previous year. The greater difference was in "other" HHS programs; budgetary resources provided were 42.4 percent greater, obligations incurred increased 35.8 percent and outlays increased 36.2 percent.

Social Insurance

The Statement of Social Insurance is presented as a basic financial statement for the first time, in accordance with Statement of Federal Financial Accounting Standards No. 25, Reclassification of Stewardship Responsibilities and Eliminating the Current Services Assessments. This Statement presents the 75-year actuarial present value of the income and expenditures of the Hospital Insurance and Supplementary Medical Insurance trust funds. Future expenditures are expected to arise from the formulas specified in current law for current and future program participations. These projections are considered to be important information regarding the potential future cost of the Medicare program.

Medicare Trust Funds

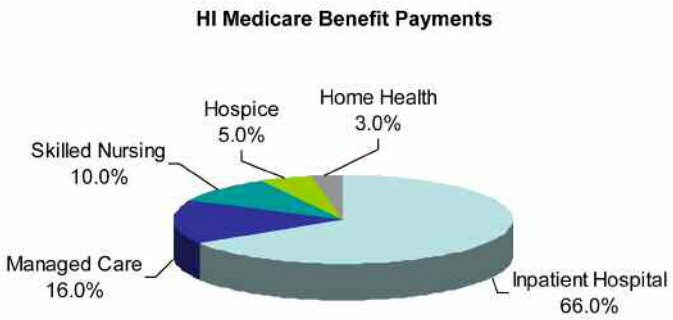
The analysis of financial statements shows that the Medicare program is by far the largest of all HHS programs. Following is a summary discussion of Medicare trust funds.

At the end of FY 2006, approximately $339,545 million ($306,100 million for Hospital Insurance and $33,445 million for Supplementary Medical Insurance trust funds) or 100 percent of HHS investments were in U.S. Treasury securities to support the Medicare trust funds. Established in 1965 as Title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people age 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. Medicare is a combination of three programs: HI, SMI, and Medicare Advantage. Since 1966 Medicare enrollment has increased from 19 million to approximately 43 million beneficiaries.

In December 2003, the President signed legislation to improve and modernize the Medicare program, including the addition of a drug benefit (Part D). The Medicare Prescription Drug program represents the largest change to the Medicare program since its enactment in 1965.

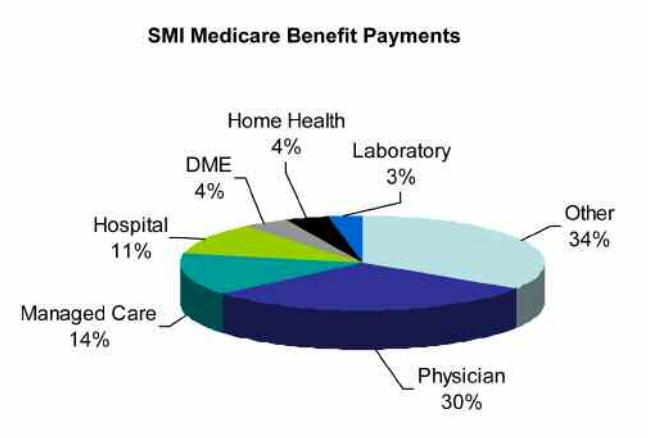
Hospital Insurance

HI or Medicare Part A, usually is provided automatically to people age 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for in-patient hospital, skilled nursing home, home health, hospice care, and managed care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and relate expenses and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.



Based on estimates from the Mid-Session Review of the FY 2007 President's Budget, inpatient hospital spending accounted for 66 percent of HI benefit outlays. Managed Care spending comprised 16 percent of total HI outlays. During HY 2006, HI benefit outlays grew by 2.4 percent. The HI benefit outlays are projected to increase by 0.8 percent to $4,360 per enrollee.

As reported in the Required Supplementary Information section of this report, HI income, including interest, continued to exceed expenditures; however, excluding interest, expenditures were slightly greater in 2006. Under the intermediate assumptions, expenditures would begin to exceed income in 2010 when including the interest as income. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2010, the trust fund would start redeeming trust fund assets; by the end of 2018, the assets would be depleted—2 years earlier than estimated in the 2005 Trustees Report. For the third year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.



Under the Trustees' intermediate set of assumptions, and as displayed in the Statement of Social Insurance, the HI trust fund will incur an actuarial deficit of nearly $11,290 billion ($11.3 trillion) over the 75-year projection period, as compared to $8,829 billion ($8.8 trillion) in the FY 2005 financial report. In order to bring the HI trust fund into actuarial balance over the next 75 years, very substantial increases in revenues and/or reductions to benefits would be required.

Supplementary Medical Insurance

SMI, or Medicare Part B and Medicare Part D, is available to nearly all people age 65 and over, the disabled, and people with end-stage renal disease who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment (DME), designated therapy, Medicare prescription drug discount care enrollment fees, managed care, prescription drug expenses for Transitional Assistance beneficiaries, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 94 percent of HI enrollees elect to enroll in SMI.

The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by the monthly premiums. As with Part A, funds not needed to pay benefits and related expenses are held in the SMI trust fund and invested in U.S. Treasury securities.

Based on estimates from the Mid-Session Review of the President's Budget, SMI benefit outlays grew by 30 percent during FY 2006. Physician services accounted for approximately 30 percent of SMI benefit outlays. During FY 2006, the SMI benefit outlays were projected to increase 28.3 percent to $4,860 per enrollee.

As reported in the Required Supplementary Information section of this report, SMI income, which includes interest on U.S. securities, is very close to expenditures, which include benefit payments as well as administrative expenses. This is because SMI funding differs fundamentally from HI. SMI Parts B and D is not based on payroll taxes, but rather on a combination of monthly beneficiary premiums and income from the U.S. Treasury. Both are established annually to cover the following year's expenditures, thus B and D accounts are automatically in financial balance every year, regardless of future economic and other conditions.

Under the Trustees' intermediate set of assumptions, and as displayed in the Statement of Social Insurance, the SMI situation over the 75-year period is entirely different from HI projections due to the financing explained above. The projected future expenditures for Part B will be $17,613 billion ($17.6 trillion) and Part D expenditures will be $10,250 billion ($10.3 trillion). This compares to FY 2005 projections of $16,571 billion ($16.6 trillion) and $11,233 billion ($11.2 trillion). A substantial level of uncertainty surrounds these projections pending the availability of sufficient data, especially on Part D expenditures, to help establish a trend baseline. Also, the reader must take into consideration that estimates have been made on the assumption that the trust fund will continue to operate without change in current law.

Limitations of the Principal Financial Statements

The principal financial statements in Section III of this report have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of 31 U.S.C. 3515 (b). While the statements have been prepared from the books and records of HHS in accordance with generally accepted accounting principles (GAAP) for Federal entities and the formats prescribed by the Office of Management and Budget, 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.

Systems, Controls, and Legal Compliance

The Department's overall goals for its financial management systems focus on ensuring effective internal controls, systems integration, and timely and reliable financial and performance data for reporting. One of the Department's immediate priorities is to address weaknesses that are identified in audits, evaluations, and assessments of it financial management controls, systems, and processes.

Systems

A cornerstone to improving HHS management practices is the Department's ability to maintain management systems, processes, and controls that ensure financial accountability; provide useful management information; and meet requirements of Federal laws, regulations, and guidance. HHS seeks to comply with a variety of Federal financial management systems requirements, including those articulated by the Federal Managers' Financial Integrity Act (FMFIA), the Chief Financial Officers Act, the Government Management Reform Act, the Clinger-Cohen Act of 1996, the Federal Financial Management Improvement Act (FFMIA), as well as the Office of Management and Budget (OMB) Circular No. A-127, Financial Management Systems. This section includes an overview of HHS' current key systems and the Department's implementation of a Unified Financial Management System (UFMS).

System Goals and Strategies

The HHS will use Oracle Federal Financials as the foundation for integrating financial management across the Department. Through UFMS, HHS seeks to establish a unified approach for enhancing financial management performance by eliminating duplication, streamlining processes, and establishing a common information technology (IT) infrastructure across the enterprise. In addition, it seeks to retain a clean audit opinion and meet the standards for success in getting to green under the President's Management Agenda initiative "Improved Financial Performance."

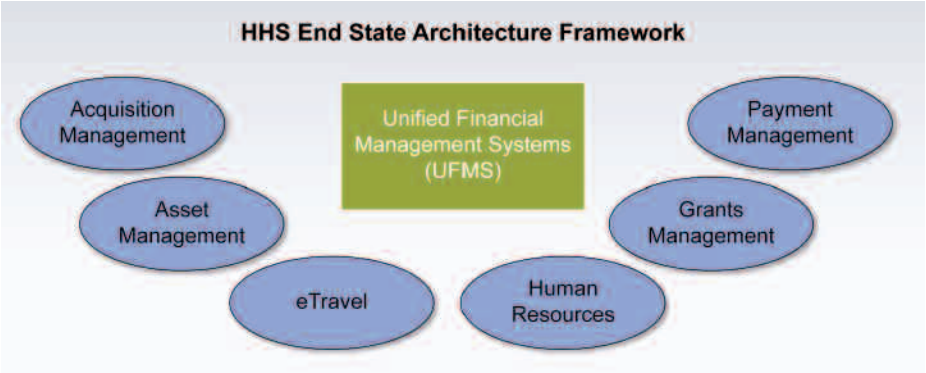
HHS' existing enterprise architecture for financial management in the Department consists of disparate, decentralized reporting systems, which are mainframe-based, rely on a mix of manual and automated processes, and are supported by varying functional and technical practices among component agencies. Since HHS and its supporting components implemented these systems, both the executive and legislative branches of the Federal Government have implemented statutes and regulations to enhance accountability and results through improved financial management. Central agencies such as OMB and the Department of the Treasury, and the Federal Accounting Standards Advisory Board have issued financial management policies, standards, and other mandates that require improvements in Federal financial management systems.

For several years, the Department has received unqualified opinions on its financial statements. However, it has been reported that the underlying financial systems that assist in the preparation of financial statements and reports do not meet all applicable requirements. To correct this situation, the Department embarked on a program to implement a UFMS.

The UFMS will replace five legacy accounting systems (PSC's CORE Accounting System, CDC's TOPS, FDA's GLAS, NIH's CAS, and CMS' FACS) with a web-based, commercial, off-the-shelf product. Once fully implemented, UFMS will reduce the legacy systems to one modern accounting system, with two components: The Healthcare Integrated General Ledger Accounting System (HIGLAS) will support CMS and the Medicare contractors and UFMS Global will serve the rest of the Department. The UFMS will:

- produce information that is timely, useful, and reliable and will support the integration of financial and performance information;
- produce the information that program managers and decision-makers will need in a timely manner and will provide the real-time processes needed to support effective e-Gov initiatives;
- result in streamlining critical administrative systems that impact financial management functions, including grants and acquisition; and
- strengthen internal controls by instituting standard business rules, data requirements, and accounting policies across the board.

In conjunction with these internal streamlining efforts, the Department will continue to ensure coordination with e-Gov initiatives efforts such as e-Travel, e-Payroll, e-Procurement, and Grants.gov. Once UFMS is fully implemented, the HHS financial management systems framework will be as depicted below:



Statement of Auditing Standards (SAS) No. 70 Service Organization

HHS has annually contracted for independent examinations of the Department's service providers to be performed under the guidelines of the American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standard (SAS) Number 70, Service Organizations as amended. In FY 2006, examinations of the Program Support Center's Division of Payment Management System, Enterprise Support Services and Division of Financial Operations, and the National Institutes of Health's Center for Information Technology service organizations were performed. The examinations were "Type 2" reports that provided an opinion on the description of controls, whether the control descriptions were suitably designed to achieve the control objectives, and if the controls had been placed in operation for the period October 1, 2005 to June 30, 2006. The independent auditors noted exceptions where (1) certain controls were not suitably designed and/or (2) certain controls were not operating effectively. These conditions resulted in the conclusion that some control objectives were not achieved. The Department is in the process of developing and/or implementing plans and systems to address deficiencies identified in these examinations.

Management Assurance

The Department of Health and Human Services' (HHS) management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of the Federal Managers' Financial Integrity Act (FMFIA) and OMB Circular No. A-123, *Management's Responsibility for Internal Control*, dated December 21, 2004. These objectives are to ensure: 1) effective and efficient operations; 2) compliance with applicable laws and regulations; and 3) reliable financial reporting.

As required by OMB Circular No. A-123, *Management's Responsibility for Internal Control*, HHS has evaluated its internal controls and financial management systems to determine whether these objectives are being met. Accordingly, HHS provides a qualified statement of assurance that its internal controls and financial systems meet the objectives of FMFIA, except for the following three material weaknesses, two of which also constitute nonconformances under Section 4 of FMFIA:

1. Medicare Advantage and Prescription Drug Benefit Payments;
2. Financial Systems and Processes (nonconformance); and
3. Medicare Electronic Data Processing Operations (nonconformance).

Assurance for Internal Control over Operations and Compliance

HHS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular No. A-123, *Management's Responsibility for Internal Control*. Based on the results of this evaluation, HHS identified one material weakness in its internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations, under Section 2 of FMFIA relating to Medicare electronic data processing operations, which also constitutes a nonconformance under Section 4 of FMFIA as of September 30, 2006. Other than the exceptions described in Attachment I, the internal controls over operations and compliance with applicable laws and regulations as of September 30, 2006, were operating effectively and no other material weaknesses were found in the design or operation of these internal controls.

Assurance for Internal Control over Financial Reporting

HHS conducted its assessment of the effectiveness of internal control over financial reporting, which includes safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of OMB Circular No. A-123, *Management's Responsibility for Internal Control*. Based on the results of this assessment, HHS identified two material weaknesses in its internal control over financial reporting as of June 30, 2006, relating to the (1) Medicare Advantage and Prescription Drug Benefit payments; and (2) Department's financial systems and processes, which also constitutes a nonconformance under Section 4 of FMFIA. Other than the exceptions described in Attachment I, the internal controls over financial reporting as of June 30, 2006, were operating effectively and no other material weaknesses were found in the design or operation of the internal control over financial reporting.

Michael O. Leavitt

NOV 15 2006

Attachment I

Summary of Material Weaknesses/Systems Nonconformances

Control Area	Material Weaknesses by Control Objective under Section 2 of FMFIA			Nonconformance under Section 4 of FMFIA (as of 9/30/06)
	Operations (as of 9/30/06)	Compliance (as of 9/30/06)	Financial Reporting (as of 6/30/06)	
I. Medicare Advantage & Prescription Drug Benefit Payments	–	–	X	–
II. Financial Systems and Processes	–	_	X	X
III. Medicare Electronic Data Processing Operations	X	–	_	X

I. Medicare Advantage and Prescription Drug Benefit Payments

HHS lacks a comprehensive control environment related to the Medicare Advantage and the Prescription Drug Benefit payment cycles administered by the Centers for Medicare and Medicaid Services (CMS). The lack of integration of accounting processes within operating procedures and a comprehensive methodology for implementation of new payment systems related to Medicare Advantage and prescription drug organizations establishes an environment where the high internal control risk is not sufficiently mitigated.

The internal controls over financial reporting related to Medicare Advantage and Prescription Drug Benefit payments were not tested during FY 2006. Management made a business decision to focus on remediation of the previously identified outstanding material weakness related to Medicare Advantage payments and implementation of the new prescription drug program that use the same payment system. HHS has focused on identifying mitigating controls and new processes that would improve the effectiveness of internal controls in the Medicare Advantage and Prescription Drug Benefit payments area.

II. Financial Systems and Processes

HHS' financial management systems are not in substantial compliance with the requirements of the Federal Financial Management Improvement Act (FFMIA) of 1996 because they do not fully comply with the Federal financial management systems requirements of OMB Circular A-127 and the United States Standard General Ledger (USSGL) at the transaction level.

As in prior years, HHS continues to have internal control weaknesses in its financial management systems and processes for producing financial statements. While progress is being made, the lack of an integrated financial management system and weaknesses in internal controls make it difficult for HHS to prepare timely and reliable financial statements. Substantial manual processes, significant adjustments to reported balances, and numerous accounting entries recorded outside the general ledger system are needed to produce the financial statements. HHS is implementing the Unified Financial Management System (UFMS) to integrate Department-wide financial management systems and operations by aligning HHS' businesses with modern technological capabilities.

III. Medicare Electronic Data Processing Operations

Internal control weaknesses were noted at the Centers for Medicare and Medicaid Services (CMS) central office and contractor sites related to electronic data processing operations. Findings were identified in logical access controls; application security, development and program change control; and systems software. This control area was reported as a reportable condition under "Medicare Electronic Data Processing Access Controls and Application Software Development and Change Control" in the Department's FY 2005 internal control report.

To strengthen internal controls in this area, the Department will implement a comprehensive strategy by focusing efforts on both short and mid-term actions needed to correct the deficiencies. Further, a comprehensive strategy will be implemented to correct individual findings at each of the contractor sites.

Corrective Action Plan and Impact of Material Weakness

The following table lists the corrective actions for the control weaknesses, the related corrective action date, and the Impact of the material weakness on the Financial Statements.

Material Weakness and Corrective Action Plan	Corrective Action Date	Impact of Control Weakness on Financial Statements
(1) Medicare Advantage and Prescription Drug Benefit Payments —Develop procedures to review and process payments, document procedures which determine eligibility of organizations, and improve oversight of providers.	Continuing throughout FY 2007	The risk level has been reduced by identifying and applying mitigating controls and new processes which have improved the effectiveness of internal controls in this area.
(2) Financial Systems and Processes—Complete implementation of UFMS.	Continuing throughout FY 2007, FY 2008 and FY 2009	The risk level has been reduced with compensating manual effort and controls.
(3) Medicare Electronic Data Processing (EDP) Operations—Implement a comprehensive strategy by focusing efforts on both short and mid-term actions to correct findings.	Continuing throughout FY 2007 and FY 2008	The risk level is reduced with the corrective action that has and is being implemented in connection with the Department's Medicare error rate determination and other activities engaged in to reduce risk.

Legal Compliance

Improper Payments Information Act of 2002

The Improper Payments Information Act of 2002 requires that the Department annually review all programs and activities that it administers and identify all such programs and activities that may be susceptible to significant improper payments. For high risk programs, the Act requires that the Department report improper payment estimates and various other related data. During FY 2006, the Department conducted reviews of its programs and activities, continued to engage in recovery auditing activity and made progress in developing and/or implementing methodologies for estimating improper payments for its seven high risk programs. However, since the Department is continuing to work on methodologies to estimate improper payments for several of its programs, it does not yet comply with the Act. Detailed information on the Department's activities to comply with the Improper Payments Information Act can be found in Section IV.

Federal Financial Management Improvement Act (FFMIA)

The FFMIA requires agencies to have financial management systems that substantially comply with the Federal financial management systems requirements, standards promulgated by the Federal Accounting Standards Advisory Board (FASAB), and the U.S. Standard General Ledger at the transaction level. Financial management systems shall have general and application controls in place in order to support management decisions by providing timely and reliable data. The agency head shall make a determination annually about whether the agency's financial management systems substantially comply with the FFMIA. If the systems are found not to be compliant, management shall develop a remediation plan to bring those systems into substantial compliance. Management shall determine whether noncompliances with FFMIA should also be reported as nonconformances with Section 4 of FMFIA.

As reported in the Department's management assurance letter, the Department does not comply with FFMIA.

Anti-Deficiency Act

The Department has discovered internal control weaknesses in a program managed by one of its operating divisions, which resulted in probable violations of the Anti-Deficiency Act (ADA). These weaknesses occurred over a period of several prior fiscal years and any amounts which could be involved would not be material to any year's financial statements. The Department is investigating these weaknesses and is committed to promptly resolving the internal control weaknesses in this program, and complying with all aspects of the ADA.

Other Management Information, Initiatives, and Issues

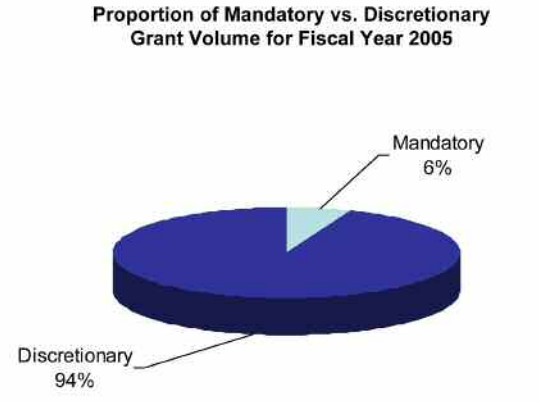
Grants Management

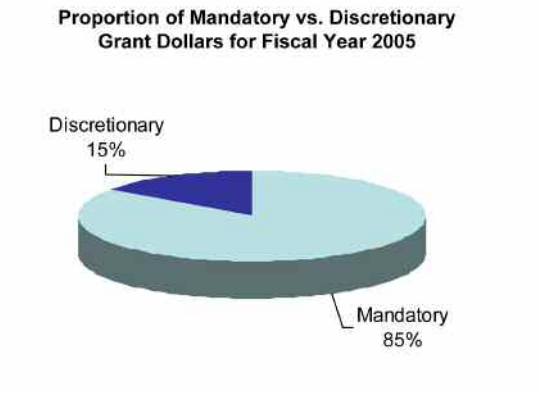
As the largest grant-awarding agency in the Federal Government, the Department plays a key role in Federal grants management. The Department is the lead agency for implementation of Public Law 106-107, the Federal Financial Management Assistance Improvement Act, which calls for grants streamlining across the 26 Federal grant-making agencies. The Department co-manages the government-wide effort with the Office of Management and Budget. Five cross-government workgroups (Pre-Award, Post-Award, Mandatory, Audit Oversight, and Training and Certification) have been established to develop government-wide streamlining policies in their respective areas. One of this year's accomplishments was to use the interagency process to develop information with respect to the effect of Hurricanes Katrina and Rita on audits conducted under Office of Management and Budget Circular No. A-133, *Audits of States, Local Governments, and Non-Profit Organizations*.

Grants.gov, one of the 24 government-wide electronic government initiatives, serves as a mechanism through which Public Law 106-107 policies are implemented in an electronic forum. The Department serves as the managing partner for Grants.gov, which allows applicants for all Federal grants to search and apply for grants in a single location. Since the initiative's inception in 2002, the Department has worked with the 26 grant-making agencies, the Office of Management and Budget, and the grants community to address long-standing inefficiencies in Federal grants processes. Grant.gov's Find and Apply accomplishes the mandates of the President's Management Agenda to provide to the public a unified, citizen-centric website that provides accurate and reliable information in a single location and simplifies the burden of the application process for the grants community.

In addition to conducting grant program stewardship and oversight responsibilities involving a variety of administrative functions, the Department also manages the Tracking Accountability in Government Grants System, which contains Department-wide grants award information. Current policies, regulations, and other pertinent grants-related information are available at http://taggs.hhs.gov.

The Department manages an assortment of grant programs in basic and applied science, public health, income support, child development, and health and social services. Through these programs, the Department awarded 76,071 grants totaling more than $241 billion in FY 2005. These programs are the Department's primary means to achieving its strategic goals.

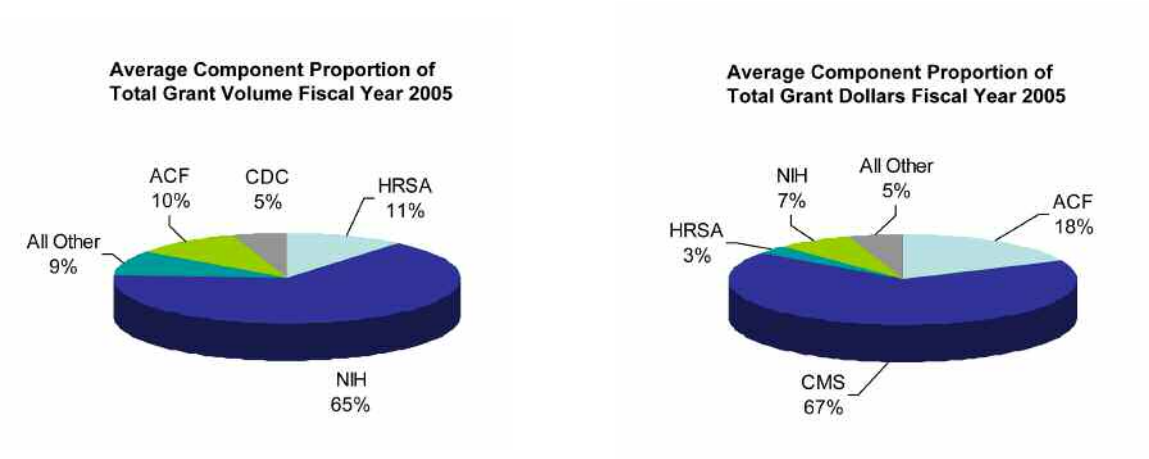




The Department awards two types of grants: mandatory and discretionary. Mandatory grants are those that a Federal agency is required by statute to award if the recipient, usually a state, submits an acceptable application and meets the eligibility and compliance requirements of the grant program's statutory and regulatory provisions. Discretionary grants permit the Federal Government, according to specific legislation, to exercise judgment in selecting the project or proposal to be supported and selecting the recipient organization through a competitive process.

As is the case with prior years, most Department-awarded grants were discretionary (94 percent of total grant volume awarded), yet most dollars associated with Departmental grants were mandatory (85 percent of total dollars awarded).

The NIH awards the majority (65 percent) of the Department's total grants, but only 7 percent of total grant dollars, indicating a low dollar per grant ratio. Still, NIH grants annually account for the majority of total Departmental discretionary dollars awarded. While ACF awards the greatest proportion of mandatory grants, CMS awards the majority of mandatory and total (67 percent) grant dollars, but only a small percentage of total grant volume, indicating a high dollar per grant ratio. The percentages of Departmental component total grant dollars and volume are essentially the same since FY 2001.



Looking Ahead to 2007 — Department Management Challenges and High-Risk Areas

The breadth of services that the Department delivers and the myriad support functions required to support them create a number of management challenges, which help set the course for Department improvement efforts each year. The Office of Inspector General (OIG) identifies these challenges and tracks Departmental progress in resolving them. Pursuant to the Reports Consolidation Act of 2000, the challenges identified by the OIG are included in this Report (see Section IV). As shown below, many of the initiatives discussed in this report, both under the auspices of the President's Management Agenda and the Department's own strategic goals, address these challenges. It should be noted that because many of the President's Management Agenda initiatives address, in great part, government-wide issues, there will not necessarily be a complete correlation between the Department's top management challenges and each of the President's Management Agenda initiatives. There is, however, a more direct relationship between the challenges identified and the Department's strategic goals. It is this relationship that articulates, in part, the Department's efforts to resolve these challenges. As such, through the Department's many initiatives, it continually strives to improve not only the quality of services it delivers to its "customers" and beneficiaries, but also to enhance management effectiveness and efficiency.

Crosswalk of HHS Challenges and Goals		
Department Top Management Challenges	**President's Management Agenda**	**Department Strategic Goal Number**
Oversight of Medicare Part D		3
Integrity of Medicare Payments	Improper Payments	8
Medicaid Administration	Improper Payments	8
Integrity of Medicaid Payments	Improper Payments	8
Payment for Medicaid Prescription Drugs	Improper Payments	8
Quality of Care in Long Term Care Services		3,5
Public Health Emergency Preparedness and Response		2
Research and Regulatory Oversight		4
Grants Management	Improved Financial Performance Expanded Electronic Government	8
Integrity of IT Systems and Infrastructure	Expanded Electronic Government	8