DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART ASSESSMENTS[1]

[1] This document contains details of the most recent program assessments as of the date the 2005 Budget was published (February 2004). Programs originally assessed for the 2004 Budget were reassessed only where evidence showed an agency's rating was likely to change. Programs not reassessed are presented in this document in the form of reprints of the original worksheets and are footnoted "FY 2004 Budget".

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Program Assessment Rating Tool (PART)

Program: 317 Immunization Program
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	70%	42%	

1.1 Is the program purpose clear? Answer: Yes Question Weight: 20%

Explanation: The goal of the National Immunization Program (NIP) is to prevent disease, disability and death in children (and increasingly) adults through vaccination. NIP is comprised of two primary grant programs to states - 1) the discretionary 317 program; and 2) the mandatory Vaccines for Children (VFC) program. The 317 grant program provides some vaccines for those who are not eligible to receive vaccines under any other insurance program, but primarily focuses on assuring vaccines for the entire population through: 1) public information and outreach; 2) quality assurance within the medical community; 3) assessment of immunizations within the population; 4) surveillance of disease and vaccine safety; 5) immunization registries; 6) vaccine management. CDC also supports global efforts such as eradicating polio and eliminating measles because to eliminate/eradicate diseases in the U.S. completely it is necessary to eliminate/eradicate them internationally.

Evidence: Cited in the NIP Strategic Plan mission and GPRA plan. The 317 program is authorized through the Public Health Service Act Section 317j, to provide vaccines for individuals (later specified as children, adolescents and adults) free of charge and to provide preventive health services related to the delivery of immunizations. With the establishment of VFC in 1994, the 317 program shifted more of its efforts towards vaccine assurance rather than direct provision of vaccines. For global activities, Congress authorizes NIP's global activities through appropriations language and NIP's strategic plan includes a goal to eliminate and eradicate diseases globally as well as domestically. However, there is no clear guiding principle for how CDC prioritizes its global activities other than that CDC works closely with WHO and its priorities to determine what international activities to undertake.

1.2 Does the program address a specific interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: CDC focuses on activities (including service delivery and supportive services) to ensure that children domestically (and increasingly adults) and internationally receive the appropriate and recommended vaccines. CDC is also using the 317 program to try and reach "pockets-of-need," or specific populations where immunization rates are much lower than the national average.

Evidence: In the U.S., 11,000 babies are born each day that must be vaccinated (approximately 4 million per year), and need to receive 12-16 doses of vaccine by 18 months, and 16-20 doses through childhood. The immunization rates for newer vaccines such as varicella and Hep. B have not yet reached 90 percent coverage. 317 also serves as a gap-filler for those children who are not receiving vaccines from any other provider.

1.3 Is the program designed to have a significant impact in addressing the interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: Although there are no good estimates for how much states contribute to vaccine purchase/infrastructure activities, NIP estimates that it provides the majority of the public funding for vaccine purchase and assurance activities. For vaccine purchase, the Federal contribution (both 317 and VFC) represents a majority of the funds (a 2000 IOM report estimates the state contribution to vaccines on the Federal contract ranges from less than 10 to 30 percent) so that increases and decreases in Federal vaccine purchase funds will have an impact on coverage levels.

Evidence: For vaccine purchase, in FY 2001, CDC estimates that states provided $116 million in purchases through the Federal contract (excluding how much states spent independently purchasing vaccines), while CDC spent $201 million in 317 funds. NIP has helped increase overall childhood immunization rates from 55 percent in 1992 to an all-time high of approximately 80% in 2000.

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1.4 Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?

Answer: Yes Question Weight: 20%

Explanation: The 317 program provides vaccines for those that do not receive vaccines through other private or public insurance programs (largely the underinsured with large copayments), and also supports outreach, education, and quality assurance activities.

Evidence:

1.5 Is the program optimally designed to address the interest, problem or need?

Answer: Yes Question Weight: 20%

Explanation: CDC provides direct financial assistance to grantees for infrastructure activities and a line of credit for vaccine purchase since it is from a single contract.

Evidence:

2.1 Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?

Answer: Yes Question Weight: 14%

Explanation: CDC's overall outcome goal is to reduce the number of indigenous cases of vaccine preventable diseases in the U.S. to 0 by 2010. NIP uses Healthy People 2010, its strategic plan and GPRA to guide and measure its activities. The five-year strategic plan (2000-2005) is more qualitative and process-oriented, and is more of a vision document to help guide CDC's overall activities, while GPRA is used to measure progress on achieving specified Healthy People 2010 goals.

Evidence: Strategic Plan examples: 1) Eradicate/eliminate/control all vaccine-preventable disease disability and death in the U.S. and globally ; 2) Raise and sustain vaccine coverage levels in all populations for all recommended vaccines.

2.2 Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?

Answer: Yes Question Weight: 14%

Explanation: The GPRA plan includes several goals to help measure progress on this long-term goal annually including vaccine coverage levels, annual targets for specific diseases, and global polio eradication efforts.

Evidence: Examples: 1) The number of indigenous cases of: a) measles will go from 63 in FY 2000 to 60 in FY 2002 to 50 in FY 2004; b) rubella will go from 176 in FY 2000 to 20 in FY 2002 to 15 in FY 2004; c) Hib from 183 in FY 2001 to 175 in FY 2002 to 150 in FY 2004; c) polio will remain at 0; 2) achieve or sustain immunization coverage of at least 90% in children 19-35 months of age for recommended vaccines each year; 3) achieve and sustain zero cases of polio by 2005.

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2.3 **Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?** Answer: Yes Question Weight: 14%

Explanation: In the FY 2003 grant announcement, NIP will require grantees to develop measurable outcomes in relation to five of its GPRA goals. Previously, NIP included 15 HP 2010 goals as the objectives that grantees should be working towards and reporting progress on in their applications.

Evidence: In FY 2003, grantees will be required to develop measurable objectives in relation to the following GPRA goals: 1) Reduce the number of indigenous cases of vaccine-preventable disease; 2) ensure that 2 year-olds are appropriately vaccinated; 3) improve vaccine safety surveillance; 4) increase routine vaccination coverage levels for adolescents; 5) increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumoccocal diseases. Previously, grantees were required to develop and measure progress on their own objectives that were in support of CDC's overarching goals.

2.4 **Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?** Answer: Yes Question Weight: 14%

Explanation: CDC leverages the National Vaccine Program Office to coordinate activities among different HHS agencies. CDC collaborates closely with NIH on IOM vaccine trials and CMS on the development of GPRA goals, reimbursement rates, and administration fees.

Evidence:

2.5 **Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?** Answer: Yes Question Weight: 14%

Explanation: In 2003, the program drafted a proposal and has entered into a contract to have an independent party conduct a comprehensive evaluation. The first phase of the evaluation will focus on the 317 program and will be paid for in FY 2003 and completed in one year. The evaluation will provide information about the interaction with the Vaccines for Children program. The program is also planning internal reviews to improve strategic planning, management, cost controls and efficiency. While NIP has undertaken several management evaluations over the past few years to see if certain aspects of the program can be improved, there have previously been no comprehensive evaluations looking at how well the program is structured/managed to achieve its overall goals. A 2000 IOM report, while comprehensive in scope, focused more on how the Federal government could improve its ability to address childhood immunizations rather than evaluating how well the 317 and VFC programs, as currently structured and operated, were improving immunization rates among children.

Evidence: Evidence includes the program revised submission and outline of focus areas for the new evaluation. Two divisions of the program have had an independent review of their management structure and operations within the last few years; NIP recently undertook an evaluation of its NIP-wide IT systems, which will have recommendations in the Fall; an independent contractor was brought in to review and help develop the NIP strategic plan; NIP brought in an independent contractor to review its indirect cost rates.

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2.6 **Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?** Answer: No Question Weight: 14%

Explanation: For the vaccine purchase activities, yes, for state infrastructure, no. For the infrastructure activities, there are a lot of different activities that comprise infrastructure (education, outreach, administration of vaccines), so it's unclear exactly how funding/policy/legislative changes will affect performance. The program is able to show after the fact the impact of changes in funding levels.

Evidence: There is no specific mechanism or measurement that links NIP's infrastructure budget and activities to its performance goals.

2.7 **Has the program taken meaningful steps to address its strategic planning deficiencies?** Answer: Yes Question Weight: 14%

Explanation: The planned evaluation described in Question 6 of this section is to provide guidance on improving the alignment of the program's budget with performance measures and information. The program anticipates this evaluation will help the program determine how budget alignment can be improved. The program is also working to develop logic models of 317 outputs. The program has made additional progress on the strategic plan and refinement of performance measures.

Evidence: Evidence includes the program revised submission and outline of focus areas for the new evaluation.

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: Yes Question Weight: 10%

Explanation: CDC collects grantee information from a variety of sources including annual progress reports from states, a financial status report, and at least one site visit per year. CDC also receives information quarterly from the National Immunization Survey (NIS) on immunization coverage across all 50 states, and disease surveillance information. CDC is moving towards a more formula-based grant in FY 2003 that will take into account more objective criteria, including performance. NIP's project officers have constant contact with grantees to determine if a change in program direction is warranted. NIP also conducts quality assurance reviews of private providers to make sure that they are administering the vaccines properly, and storing/rotating them.

Evidence: Disease rates from surveillance and the National Immunization Survey have helped CDC determine internal priorities (e.g., what diseases/populations scientists should be looking at), and their activities in collaboration with states, as well as how well their grantees are achieving immunization coverage levels. For grantees, if CDC sees that there are low immunization levels within a jurisdiction, CDC may provide technical assistance or direct additional funds to this area.

3.2 **Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?** Answer: No Question Weight: 10%

Explanation: NIP's Federal program managers, while responsible for cost and schedule, do not have performance-based contracts that integrate program performance into their personnel evaluations. Within CDC, only SES have performance-based contracts and NIP has no SES. For grantees, while NIP reviews grantees vaccine coverage levels and progress reports to determine if they are meeting their stated objectives, NIP doesnt reallocate funds as a result of grantees not meeting their objectives, and tends to provide technical assistance instead. CDC is in the process of initiating performance contracts for center and division directors, but has not gone through all of the steps to put them in place at this time. The program also is updating the AFIX and Provider Quality Assurances to improve physician practices. A new review panel is planned to improve accountability of grantees.

Evidence: Evidence includes the agency submissions.

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3.3 **Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: Yes Question Weight: 10%

Explanation: NIP generally obligates almost all of its funds by the end of the year, and has many mechanisms to make sure that grantees spend their funding for the intended purpose.

Evidence: Grantees tend to have less than 10% of their obligations carried over to the following year (approx. $1,000-$100,000) and have to use their carry-over in lieu of new funds. NIP also conducts site visits to assess grantee obligation patterns and how funds are spent, and interacts frequently with grantees through conference calls to monitor activities and progress. Grantees are required to provide a detailed budget by object class, so if they want to move funds around they have to notify CDC. CDC's central program and grants office has also started site visits to focus on management/funding issues.

3.4 **Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: Yes Question Weight: 10%

Explanation: The program hired a contractor to do a baseline assessment of IT activities and is consolidating all IT into the office of the director. The change realigns branches and eliminates a division. A second phase of the effort will examine administrative staff to determine available efficiencies and savings. The operations manual includes efficiency measures on vaccine wastage that grantees report on to CDC. Improvements in efficiency is also a focus of a new evaluation being contracted by the program. The program has committed to additional efficiency measures and further steps to put procedures in place to regularly review potential efficiencies and cost-effectiveness in administering the program are warranted. Additional steps to improve the efficiency of vaccine distribution should be examined.

Evidence: Reorganization plans were announced in March 2003. Efficiencies: NIP is converting to some electronic processing, including its disease reporting system, vaccine ordering system, and collecting records from providers to improve efficiency, and is undertaking a comprehensive review of its IT positions/activities. While CDC centrally cost-competes for certain procurement and other administrative activities, the program doesnt cost-compete for services. Cost-Effectiveness: There are no dollars per unit service. CDC has achieved some cost savings in vaccine purchase through having a single Federal contract, contracts with multiple manufacturers and re-competing vaccine bids every four years. NIP also contracts with GSA to help states establish vaccine registries.

3.5 **Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?** Answer: No Question Weight: 10%

Explanation: While CDC includes the full cost of its activities including overhead, program performance cannot be readily identified with changes in funding levels.

Evidence: Evidence based on GPRA plans and reports and budget justifications.

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3.6 Does the program use strong financial management practices? Answer: No Question Weight: 10%

Explanation: The FY 2002 report noted reportable conditions relating to information systems; the internal controls over preparation, analysis and monitoring of financial information, including manually intensive procedures; reimbursable agreements; and grants accounting and oversight. None of the reportable conditions are considered material internal control weaknesses. CDC has actively addressed key areas. CDC automated reimbursable billings, enhanced year end closing transactions and implemented a new indirect cost methodology. CDC is also addressing staffing needs, including core accounting competencies, professional staff recruitment, financial systems, training and customer service.

Evidence: Evidence includes the FY 2002 Chief Financial Officers annual report, including summary of reportable conditions, summary documents on end of year balances, OIG reports (e.g., CIN-A-04-98-04220). Four areas of findings were also documented the prior year. CDC has received five consecutive unqualified opinions on the agency's financial statements. Additional data include that CDC issued 64 duplicate or erroneous payments in FY 2002, or 0.042% of all payments and has a 97% compliance rate for prompt payments.

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: Yes Question Weight: 10%

Explanation: As noted above, the agency is actively addressing financial management. In its FY 2003 application, NIP is trying to formalize its application criteria, requiring grantees to provide more quantifiable objective information in its application and annual progress reports, and developing more clear evaluation criteria. NIP has also contracted with a firm to review its IT organizational structure and develop a 5-year plan to help improve the efficiency of NIP. As noted above, the program is also planning performance contracts for federal managers once the CDC executive team performance plans are in place. A review panel is being established for fall grantee reviews to improve consistency of awards and oversight of grantees.

Evidence: Grantee applications will be ranked based on: 1) plan; 2) objectives; 3) methods; 4) evaluation; previously, grantees were primarily funded based on population and need.

3.CO1 Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process? Answer: Yes Question Weight: 10%

Explanation: NIP assigns project officers to review the applications and determine how much funding each state should receive. Before FY 2003, the funding decisions were based upon the information included in individual grantee applications, taking into account historical funding levels and factors like state need/population/poverty levels. In FY 2003, CDC is formalizing this process to include clear criteria for allocating resources.

Evidence: In FY 2003, NIP will use the following criteria to rank applications: 1) plan; 2) objectives; 3) methods; 4) evaluation.

3.CO2 Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process? Answer: NA Question Weight: 0%

Explanation: NIP provides funding to all 50 states.

Evidence:

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3.CO3 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: Yes Question Weight: 10%

Explanation: CDC collects information from a variety of sources, including disease surveillance reports, annual progress reports, and site visits. States also conduct annual program reviews of local health departments and intensive reviews of immunization clinics.

Evidence:

3.CO4 **Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: Yes Question Weight: 10%

Explanation: NIP makes both aggregate and state performance information on coverage levels and disease burden available through its website and Morbidity and Mortality Weekly reports.

Evidence:

4.1 **Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?** Answer: Large Extent Question Weight: 25%

Explanation: CDC has made significant progress in achieving its long-term goals.

Evidence:

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: Large Extent Question Weight: 25%

Explanation: CDC has largely achieved its annual goals.

Evidence:

4.3 **Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?** Answer: No Question Weight: 25%

Explanation: While NIP has achieved some cost savings through negotiating a single Federal contract, the program does not have a stated efficiency or cost-effectiveness goal to measure progress in this area.

Evidence:

4.4 **Does the performance of this program compare favorably to other programs with similar purpose and goals?** Answer: N/A Question Weight: 0%

Explanation: While VFC is similar to the 317 program, VFC serves a distinct population and focuses primarily on vaccine purchase. The 317 program does some vaccine purchase but also provides a lot of support for activities that cover the entire population including education, outreach, and surveillance.

Evidence:

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4.5 **Do independent and quality evaluations of this program indicate that the program is effective and achieving results?**

Answer: Small Extent

Question Weight: 25%

Explanation: While the more comprehensive IOM report indicated that childhood immunization levels are at an all-time high and the program has helped contribute to this outcome, this report focused more on the appropriate role of the Federal government rather than evaluating whether the 317 program, as currently structured/managed was effective at improving immunization rates among children.

Evidence:

PART Performance Measurements

Program: 317 Immunization Program

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Number of cases of vaccine-preventable diseases in the United States as measured by cases of polio, rubella, measles, congenital rubella, mumps and tetanus.

Additional Information: Target:Goal is 0: Polio (from 0), Rubella (from 181 in 1997), Measles (From 81 in 1997), Diphtheria (from 3 in 1997), Congenital Rubella (from 5 in 1997), Mumps (from 683 in 1997), Tetanus (From 50 in 1997) Actual Progress achieved toward goal: 2001 Data: Polio: 0; Rubella: 19; Measles: 61; Hib: 183; Diphtheria: 2; Congenital Rubella: 2; Tetanus: 27, Mumps: 231.

Year	Target	Actual	**Measure Term:** Long-term
2001	<150	<183	
2010	0		

Measure: Percentage of children 19-35 months of age who receive recommended vaccines every year.

Additional Information: Performance Target: 90% Actual Performance: All at or past 90% except Varicella at 68%

Year	Target	Actual	**Measure Term:** Annual
2001	90%	>=90% var. 68%	
2004	90%		

Measure: Number of polio cases worldwide.

Additional Information: Performance Target: FY 02: 500 cases; FY 03: 200 cases. Actual Performance:FY 2001: 483 cases

Year	Target	Actual	**Measure Term:** Annual
2001		483	
2002	500		
2003	200		

Program Assessment Rating Tool (PART)

Program: Administration on Aging
Agency: Department of Health and Human Services
Bureau: Administration on Aging
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
100%	75%	100%	67%	Moderately Effective

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The purpose of Title III of the Older Americans Act (OAA) is to assist State and local agencies on aging to enter into new cooperative arrangements in order to concentrate resources and expand the capacity to provide comprehensive and coordinated systems in each state. The objectives of the Title III programs (congregate meals, home-delivered meals, supportive services and centers, preventive health care, and support of family caregivers) are to: (1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services; (2) remove individual and social barriers to economic and personal independence for older individuals; (3) provide a continuum of care for vulnerable older individuals; and (4) secure the opportunity for older individuals to receive managed in-home and community-based long-term care services.

Evidence: The purpose and objectives of Title III - Grants for State and Community Programs on Aging, are found in Section 301(a) of the OAA.

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The elderly suffer higher levels of disease and disability than other population age groups. Title III provides an array of services to reduce vulnerability to and the effects of disease and disability in order to allow vulnerable elderly individuals to remain in their homes. Title III provides meals to elderly individuals in congregate and home settings; transportation to senior centers, medical appointments, and other venues in the conduct of daily business; services to family members who care for the elderly; and preventive health services, such as exercise programs in senior centers.

Evidence: A meta-analysis of nutrition studies showed that almost two thirds of older persons were at nutritional risk. Recent AoA data show that 87% of new clients in the Congregate Nutrition Program have high (37%) or moderate (50%) degrees of nutritional risk. Data from the CSFI (USDA) and the Behavioral Risk Factor Surveillance System indicate significant areas of nutritional deficits among the older population. A May 1999 GAO report, "Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services," states: "obtaining personal care on what is often a daily basis is critical for avoiding institutionalization."

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: No other federal program provides the combination of services contained in Title III. By design, Title III provides the infrastructure for State and Area Agencies on Aging, and the related service providers, which integrates funding from State and local sources along with federal funds. This infrastructure (commonly referred to as the "Aging Network") provides the leadership to insure that State and local support continues as service systems evolve.

Evidence: Mathematica evaluation: "Serving Elders at Risk: A National Evaluation of Older Americans Act Nutrition Programs" (1996).Title III of the OAA.

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1.4 **Is the program design free of major flaws that would limit the program's effectiveness or efficiency?** Answer: YES Question Weight: 20%

Explanation: Funding for the Title III community-based services program is determined by formula (based on the number of persons 60+ in the state) and provides flexibility to State and local entities to target the needs of the elderly in communities. This approach has generated positive system results for the program as indicated by leveraging of funds, program income generated, and participation by volunteers. The flexibility of the State and local entities to transfer dollars among programs enhances program design.

Evidence: States and communities leverage about $1.90, and raise $.30 in revenue, for every OAA dollar. Over 40% of the staff of area agencies on aging are volunteers. In accordance with OAA Section 308 b(4)C, States are able to transfer funds among services (e.g., from congregate meals to supportive services) to meet local needs.

1.5 **Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly?** Answer: YES Question Weight: 20%

Explanation: The Older Americans Act programs provide services to persons aged 60 and over. The Act requires that services be targeted to the vulnerable elderly (low income, low income minority, rural, disabled and frail) to enable them to live independently as long as possible. State plan requirements (Section 307 of OAA) and Area Agency on Aging plan requirements (Section 306 of OAA) require commitment and planning for targeting services to vulnerable populations. The Aging Network successfully targets services to the vulnerable and AoA monitors targeting through NAPIS .

Evidence: Rural: 23% of elderly population; 29.8% of Title III recipients -- Low income: 10.2% of elderly population; 29% of Title III recipients (34.5% are minority) -- Disabled and Frail -- 79% of recipients of home-delivered meals have one or more ADL limitation; 99% have one or more IADL -- 85.9% of recipients of homemaker services have one or more ADL limitation; 99% have one or more IADL limitation. Sources: Older Americans Act, NAPIS data and the 2002 National Survey of Older Americans Act Participants.

2.1 **Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program?** Answer: YES Question Weight: 12%

Explanation: AoA has implemented a Strategic Action Plan with long-term outcome goals that reflect program purpose and the rebalancing initiative and AoA's efforts to enhance service integration.

Evidence: AoA Strategic Action Plan and FY 2005 Budget - Congressional Justification.

2.2 **Does the program have ambitious targets and timeframes for its long-term measures?** Answer: YES Question Weight: 12%

Explanation: AoA has implemented a Strategic Action Plan with long-term outcome goals that reflect program purpose and the rebalancing initiative and AoA's efforts to enhance service integration.

Evidence: AoA Strategic Action Plan and FY 2005 Budget - Congressional Justification.

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2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 12%

Explanation: AoA's annual measures have evolved from early service counts, to the incorporation of targeting and systems (efficiency) measures to, in the FY 2005 performance plan, the incorporation of new outcome measures which will examine program efficacy and track the successful participation of the Aging Network in the rebalancing initiative and services integration efforts.

Evidence: FY 2005 Budget - Congressional Justification; AoA Strategic Plan

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: All of the FY 2005 performance measures for Title III programs have baselines and targets that are ambitious, consistent with budget constraints.

Evidence: FY 2005 Budget - Congressional Justification; AoA Strategic Plan

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: NO Question Weight: 12%

Explanation: AoA does not have the authority to require state or local agencies to adopt the AoA goals. However, state and area agencies were consulted in the identification of performance measures for GPRA plans, and state and local data is used for each of the measures. State plans include performance measures.

Evidence: AoA supports grants and cooperative agreements with States for Performance Outcome Measurement Projects (POMP) to develop improved outcome measures which meet both Federal, State, and local needs. Twenty states currently participate in the POMP program.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: YES Question Weight: 12%

Explanation: The AoA evaluates major programs on a 10-year basis. The most recent evaluation of the OAA Nutrition Programs, by Mathematica Policy Research, was released in 1996. The other programs under Title III were not explicitly included in this evaluation, though it acknowledged that the nutrition programs could not be fully disaggregated from the other support programs. AoA is conducting annual performance assessment surveys of nutrition and support services to assure continuous program monitoring. Consistent with AoA's current evaluation plan, work commenced in FY 2003 for the Evaluation of the Health Promotion and Disease Prevention Program; in FY 2004 work will commence on the evaluation of the nutrition programs/ support services programs (groundwork was begun in FY 2003). The evaluation of nutrition and support services will be integrated. Results from POMP and the national surveys will be used to inform the evaluation; POMP grantees will be members of the "technical expert" panel for the evaluation.

Evidence: POMP Grant Announcement, application narratives. Evaluation Status/Evaluation Plan; Statement of Work for POMP TA, SOW for Health Promotion Disease Prevention evaluation. Results of First National Survey.

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100%	75%	100%	67%	Moderately Effective

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: AoA's budget and GPRA program structures are the same to foster the use of GPRA program results to support AoA budget requests. AoA states its funding priorities for its budget request are based on observations made directly from GPRA program reports and other program data. It does not appear that the effect of funding, policy or legislative changes on performance is readily known.

Evidence: AoA annual performance plan and congressional justification.

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: AoA has implemented a Strategic Action Plan with long-term goals and annual work plans identified. AoA has also worked to further integrate performance measurement into the budget process and works closely with State and local partners on the program performance measures from which our newly developed outcome measures have evolved. These new measures have been incorporated into the FY 2005 performance plan and AoA's Strategic Plan.

Evidence: AoA Strategic Action Plan and FY 2005 Budget - Congressional Justification.

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 12%

Explanation: AoA has a National Aging Program Information Systems (NAPIS) through which the states annually submit detailed aggregate data on the services provided by the Title III program (State Program Reports - SPR) as well as the characteristics of program participants. AoA reviews, validates, and certifies this program data. Improvements in this process have greatly shortened the time needed by the States to submit this data and the time needed for review and certification by AoA. AoA added 8 intermediate outcome measures addressing improvements by States.

Evidence: The NAPIS/SPR data is used directly in AoA GPRA outcome measures to set objectives for state performance. AoA and the States have reduced annual data lags by 11 months over the last three years. FY 1998 data were certified in February, 2001 - 29 months after the end of FY 1998; FY 1999 data was certified in September 2001, -23 months after the end of FY 1999 and FY 2000 data was certified in April 2002, 18 months after the end of FY 2000.

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 12%

Explanation: It is the responsibility of AoA managers to pursue improvement of program management and performance; their contracts link to GPRA performance measures. AoA does not have the authority to hold State and local agencies accountable; however, AoA does assist agencies that fall short of their goals to identify and fix deficiencies. While OAA funding is determined by formula as specified in the OAA, there are incentives to encourage better performance, including additional funds based on the number of meals provided in the nutrition programs, as well as for states to improve performance measurement (POMP project).

Evidence: AoA manager performance contracts.

Program Assessment Rating Tool (PART)

Program: Administration on Aging
Agency: Department of Health and Human Services
Bureau: Administration on Aging
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
100%	75%	100%	67%	Moderately Effective

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 12%

Explanation: Federal funds for this program are made available within a few days after the appropriation act is signed by the President. This is consistent with the intent of Congress. Grantees (States) provide semi-annual Financial Status Reports to show that the funds are spent for the intended purposes. Future grants are not awarded unless the grantees comply with expenditure requirements.

Evidence: Financial management requirements. SF 269. Single State Audits.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: YES Question Weight: 12%

Explanation: Since Community-based programs are administered at the local level, by AAAs, efforts to achieve efficiencies must be directed toward the AAAs. AoA monitors performance on key Aging Network systems measures and we have developed a new efficiency performance measure (number served per $million) which demonstrates the efficiency of the Aging Network. AoA is engaged in on-going activities to enhance performance at the State/local level including: 1) the Performance Outcomes Measures Project (POMP) to develop performance measurement tools for State/local agency use in assessing /improving program performance and 2) a cooperative agreement with NASUA to assist in the development of information sytems for the collection of program information. Our service integration efforts (e.g. Aging One-Stop Shops) are geared toward improved cross-program efficiencies and better service. We also have an existing efficiency measure to monitor, at the Federal level, improved timeliness of data.

Evidence: FY 2005 GPRA plans, AoA Strategic Action Plan, POMP program announcements, cooperative agreements and website www.gpra.net, Cooperative agreements with NASUA , Program announcements for services integration projects

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 12%

Explanation: On the Federal level, AoA coordinates with other programs to provide information, guidance and funds to state and local agencies. The OAA also supports the infrastructure of the Aging Network, which encourages collaboration on the state and local level, and shares information on best practices as well as how collaboration can be enhanced.

Evidence: State Program Reports. Examples of AoA interagency collaboration to assist the Aging Network includes developing with the Center for Medicare and Medicaid Services the Real Choice Systems Change grants announcement, and the Nursing Home Quality Improvement Initiative statement of work. Examples of Federal-state collaboration: (1) 31 state agencies on aging administer the Medicaid Home and Community-based Services waiver program; and (2) AoA, the Centers for Disease Control and state agencies on aging and health departments are developing an integrated system of health promotion for the elderly.

3.6 Does the program use strong financial management practices? Answer: YES Question Weight: 12%

Explanation: While exercising sound financial management control within AoA, the agency utilizes the financial management services of HHS and the Program Support Center for the vast majority of its financial management processes and activities. AoA has achieved two consecutive clean opinions in financial statement audits, and no material weaknesses were identified in those audits.

Evidence: AoA Financial Statement Audit Memos.

Program Assessment Rating Tool (PART)

Program: Administration on Aging
Agency: Department of Health and Human Services
Bureau: Administration on Aging
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
100%	75%	100%	67%	Moderately Effective

3.7 **Has the program taken meaningful steps to address its management deficiencies?** Answer: NA Question Weight: 0%

Explanation: Numerous initiatives to enhance service integration and improve program performance and information systems at the State and AAA level have been undertaken. A new efficiency measure has been incorporated into the FY 2005 GPRA plan.

Evidence: See 3.4 above.

3.BF1 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: YES Question Weight: 12%

Explanation: The grantees are required to submit a state or area plan on a periodic basis which are reviewed and approved by AoA staff. AoA staff performs annual site visits to the State Units on Aging. AoA Regional Office personnel are also in continuous contact with the States.

Evidence: Copies of state plans are maintained in AoA for review by internal and external groups. These plans are reviewed as part of the Financial Audit.

3.BF2 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: YES Question Weight: 12%

Explanation: AoA collects, compiles and disseminates program performance data on an annual basis through the National Aging Program Information System, which includes standardized electronic submission, and formal verification, validation and certification processes. Upon certification, data for all States are disseminated to the public via the Internet and other mechanisms, including GPRA reports.

Evidence: All of the State Program Reports may be viewed on the AoA web site at: http://www.aoa.gov/prof/agingnet/napis/napis.asp

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: Adequate progress is demonstrated for long-term goals associated with targeting, leveraged funding and people served per $million. However, our other long-term outcome measures are new, based on survey data that is just becoming available. It is too soon to show progress toward the new long-term goals although the survey results show very high consumer satisfaction ratings for all services surveyed.

Evidence: AoA Strategic Plan, FY 2005 Budget - Congressional Justification,

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: AoA's annual performance measures have evolved from early service counts, to the incorporation of targeting and systems (efficiency) measures to, in the FY 2005 performance plan, the incorporation of new outcome measures . Performance for targeting measures has been consistently above the percentage of the targeted group in the +60 population and systems measures show high levels of leveraged funding, contributions and volunteers. Service count results have been mixed (home delivered meals has risen) but consistent with budgets. Program partners provide all of the performance information we utilize; they work collaboratively on the development of SPR requirements and POMP participants developed the performance measures utilized in the first National Survey.

Evidence: FY 2005udget - Congressional Justification; NAPIS data and Performance Outcomes Measures Project website: www.gpra.net.

Program Assessment Rating Tool (PART)

Program: Administration on Aging
Agency: Department of Health and Human Services
Bureau: Administration on Aging
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
100%	75%	100%	67%	Moderately Effective

4.3 **Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** Answer: YES Question Weight: 25%

Explanation: The Aging Network, employing the tools described in 3.4 above, efficiently provides State and Community-based services which is demonstrated by trend data for our efficiency measure: people served per $million of AoA (Title III) funding.

Evidence: FY 1999: 6,293 people served per $million; FY 2000: 6,373 people served per $ million; FY 2001: 6,425 people served per $million; FY 2002: 6,495 people served per $ million. Data sources: NAPIS data system and Budgets. Note: these trend calculations exclude caregiver program data to make the four years comparable. Our new performance measure will include the caregiver program.

4.4 **Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?** Answer: NA Question Weight: 0%

Explanation: There are no similar federal programs. The results are consistent across AoA's programs for home and community services. AoA's results incorporate performance of State and local programs managed by the Aging Network.

Evidence:

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?** Answer: YES Question Weight: 25%

Explanation: The 1996 evaluation of the nutrition programs found: 1) nutrition of clients better than non-clients; 2) improved social interaction; 3) leveraged funding; 4) coordinated service access and delivery with health and social services; and 5) effective targeting of the vulnerable. The evaluation did not find any significant program deficiencies. AoA indicated that future evaluations would include other components of the Title III programs.

Evidence: Mathematica evaluation: "Serving Elders at Risk: A National Evaluation of Older Americans Act Nutrition Programs" (1996).

PART Performance Measurements

Program: Administration on Aging

Agency: Department of Health and Human Services

Bureau: Administration on Aging

Measure: People served per $million of AoA funding (with no decline in service quality)

Additional Information: The purpose of this measure is to demonstrate the success the Aging Network demonstrates in employing available tools (see Section 3.4) to enhance the use of AoA funds. This measure will be monitored in conjunction with consumer assessment of service quality (measures12-17) to assure that increased efficiency does not result in declining service quality.

Year	Target	Actual
2001		5,688
2004	Baseline +6%	
2005	Baseline +8%	
2006	Baseline+10%	
2007	Baseline+15%	

Measure Term: Long-term (Efficiency Measure)

Measure: Percent of congregate meal recipients satisfied with the way food tastes

Additional Information: This measure, in conjunction with measures 1 and 2 above, will monitor consumer satisfaction and/or service assessment as increased efficiencies are realized to assure there is no decline in service quality.

Year	Target	Actual
2003		92.89%
2004	92.89%	

Measure Term: Annual

Measure: Percent of transportation service recipients rating the service very good to excellent

Additional Information: This measure, in conjunction with measures 1 and 2 above, will monitor consumer satisfaction and/or service assessment as increased efficiencies are realized to assure there is no decline in service quality.

Year	Target	Actual
2003		82.3%
2005	82.3%	

Measure Term: Annual

PART Performance Measurements

Program: Administration on Aging

Agency: Department of Health and Human Services

Bureau: Administration on Aging

Measure: Number of Callers to Information and Assistance reporting information received was helpful.

Additional Information: This measure, in conjunction with measures 1 and 2 above, will monitor consumer satisfaction and/or service assessment as increased efficiencies are realized to assure there is no decline in service quality.

Year	Target	Actual	**Measure Term:** Annual
2003		9.822M	
2004	9.986M		
2006	10.313M		

Measure: Percent of Caregivers rating case management services as good to excellent.

Additional Information: This measure, in conjunction with measures 1 and 2 above, will monitor consumer satisfaction and/or service assessment as increased efficiencies are realized to assure there is no decline in service quality.

Year	Target	Actual	**Measure Term:** Annual
2003		87.2%	
2004	87.2%		
2005	87.2%		

Measure: Percent of Title III recipients rating services good to excellent.

Additional Information: This measure, in conjunction with measures 1 and 2 above, will monitor consumer satisfaction and/or service assessment as increased efficiencies are realized to assure there is no decline in service quality.

Year	Target	Actual	**Measure Term:** Long-term
2007	90%		

Measure: Time lag (in months) for making NAPIS data available

Additional Information: The purpose of this measure is demonstrate Federal management efficiencies by improving the timeliness of program data availibility.

Year	Target	Actual	**Measure Term:** Long-term (Efficiency Measure)
1998		26 months	
2001	15 months	15 months	

PART Performance Measurements

Program: Administration on Aging

Agency: Department of Health and Human Services

Bureau: Administration on Aging

Measure: Time lag (in months) for making NAPIS data available

Additional Information: The purpose of this measure is demonstrate Federal management efficiencies by improving the timeliness of program data availibility.

Year	Target	Actual
2004	13 months	
2005	12 months	
2009	6 months	

Measure Term: Long-term (Efficiency Measure)

Measure: People served per $million of AoA funding (with no decline in service quality).

Additional Information: The purpose of this measure is to demonstrate the success the Aging Network demonstrates in employing available tools (see Section 3.4) to enhance the use of AoA funds. This measure will be monitored in conjunction with consumer assessment of service quality (measures12-17) to assure that increased efficiency does not result in declining service quality.

Year	Target	Actual
2001	Baseline	5,800
2004	Baseline +6%	
2005	Baseline +8%	
2006	Baseline+10%	
2007	Baseline+15%	

Measure Term: Annual (Efficiency Measure)

Measure: By 2010, the number of states achieving a targeting index (which is the percentage of service recipients that live in rural areas or in poverty, divided by the overall percentage of the age 60+ population that live in rural areas or in poverty) greater than 1.0 for rural and poverty measures.

Additional Information: {TARGETING INDEX= % of Title III recipients that are rural/ % of 60+ population that are rural} The purpose of this measure is to demonstrate continuous program improvement in targeting services to vulnerable elderly as required by the OAA. Note: Baseline (year 2001) targeting indexes for all States have been developed for poverty targeting. The rural baseline is preliminary pending special Census tabulations.

Year	Target	Actual
2001	(poverty)	44
2001	(rural)	41
2010	51 States P	

Measure Term: Long-term

PART Performance Measurements

Program: Administration on Aging

Agency: Department of Health and Human Services

Bureau: Administration on Aging

Measure: By 2010, the number of states achieving a targeting index (which is the percentage of service recipients that live in rural areas or in poverty, divided by the overall percentage of the age 60+ population that live in rural areas or in poverty) greater than 1.0 for rural and poverty measures.

Additional Information: {TARGETING INDEX= % of Title III recipients that are rural/ % of 60+ population that are rural} The purpose of this measure is to demonstrate continuous program improvement in targeting services to vulnerable elderly as required by the OAA. Note: Baseline (year 2001) targeting indexes for all States have been developed for poverty targeting. The rural baseline is preliminary pending special Census tabulations.

Year	Target	Actual	**Measure Term:** Long-term
2010	50 States R		

Measure: OAA program participation by poor in States

Additional Information: The purpose of this measure is increase the number of States performing below the national average targeting index in FY 2000 who increase and sustain the percent of below poverty elderly they serve. In 2000 there were 25 States performing below the average.

Year	Target	Actual	**Measure Term:** Annual
2001		8 States	
2003	5		
2004	9		
2005	13		

Measure: The percentage of caregivers reporting that services have definitely enabled them to provide care for a longer period.

Additional Information: The intent of this measure is to show an increase in the percentage of caregivers reporting that services have definitely enabled them to provide care for a longer period. This will measure the successful maturation of the caregiver program and the success of the Department's rebalancing initiative.

Year	Target	Actual	**Measure Term:** Long-term
2003		48%	
2004	55%		
2005	62%		
2006	68%		
2007	75%		

PART Performance Measurements

Program: Administration on Aging

Agency: Department of Health and Human Services

Bureau: Administration on Aging

Measure: Caregivers reporting difficulties in dealing with agencies to obtain services.

Additional Information: The intent of this measure is to show a decline in the percentage of caregivers reporting difficulty in dealing with agencies to obtain services This will measure the successful maturation of the caregiver program and the success of the Department's efforts to integrate long-term care service provision.

Year	Target	Actual	**Measure Term:** Annual
2003		0.642	
2004	0.57		
2005	0.5		
2006	0.43		
2007	0.35		

Measure: Number of caregivers served

Additional Information: The purpose of this measure is to gauge the success of program implementation. The caregiver program is new - reaching the intended recipients is the first step.

Year	Target	Actual	**Measure Term:** Annual
2002		435,000	
2003	250,000		
2004	610,000		
2005	800,000		
2007	1 million		

Measure: Number of Home delivered meal clients and homemaker clients with 3 or more ADL limitations (nursing home eligible)

Additional Information: As efforts continue to rebalance the provision of long-term care services with an emphasis on home and community- based services, the aging network will demonstrate their successful contribution to the initiative by serving increasing numbers of frail or disabled elderly.

Year	Target	Actual	**Measure Term:** Annual
2003	(Meals)	280,454	
2003	(Homemaker)	70,615	

PART Performance Measurements

Program: Administration on Aging

Agency: Department of Health and Human Services

Bureau: Administration on Aging

Measure: Number of Home delivered meal clients and homemaker clients with 3 or more ADL limitations (nursing home eligible)

Additional Information: As efforts continue to rebalance the provision of long-term care services with an emphasis on home and community- based services, the aging network will demonstrate their successful contribution to the initiative by serving increasing numbers of frail or disabled elderly.

Year	Target	Actual	**Measure Term:** Annual
2005	Baseline+8%		
2006	Baseline +15%		
2007	Baseline +25%		

Measure: Percent of Home-delivered meal recipients reporting they like the meals

Additional Information: This measure, in conjunction with measures 1 and 2 above, will monitor consumer satisfaction and/or service assessment as increased efficiencies are realized to assure there is no decline in service quality.

Year	Target	Actual	**Measure Term:** Annual
2003		93.1%	
2004	93.1%		
2005	93.1%		

Program Assessment Rating Tool (PART)

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The program purpose is to prevent harmful exposures and disease related to toxic substances through science, public health actions and health information. The program is active in Superfund sites and other potential sources of toxic substance exposure, the Great Lakes basin, and in some aspects of terrorism preparedness and response. The agency's approach to sites where toxic substances are present is to provide health education, risk communication, environmental medicine and health promotion. The agency's mission statements, planning and budget documents are consistent with the authorizing legislation.

Evidence: The Comprehensive Environmental Response, Compensation and Liability Act of 1980 (Superfund) designates ATSDR as the lead public health agency with responsibility for assessing health hazards and helping to prevent or reduce exposure and illness at hazardous waste sites identified by the Environmental Protection Agency's national priorities list for uncontrolled hazardous waste sites and for increasing knowledge of the health effects that may result from exposure to hazardous substances. The Superfund Amendments and Reauthorization Act of 1986 increased the number of required health assessments, expanded toxicology databases and medical education activities and required a report to Congress on childhood lead poisoning. ATSDR conducts public health assessments and research under the Resource Conservation and Recovery Act of 1976 and the Great Lakes Critical Programs Act. There is no specific authorizing legislation detailing ATSDR's role in terrorism preparedness and response.

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The program addresses the problem of human exposure to toxic substances at hazardous waste sites. An estimated 15 million people live within one mile of the over 1,600 hazardous waste sites on the National Priorities List targeted by the Environmental Protection Agency. The number of people living within one mile of a toxic waste site addressed by ATSDR increased from one million in 1996 to 2.5 million in 2000 and the number of sites increased from 390 to 707. Over the past year, ATSDR worked in 425 communities where nearly 300,000 people have been exposed to toxic substances. Health problems that may be caused by hazardous substances include cancer, kidney dysfunction, lung and respiratory disease, birth defects and reproductive disorders, immune function disorders, liver dysfunction and neurotoxin disorders. The conditions identified as a priority by the agency impact millions of Americans.

Evidence: Substances most frequently found at NPL sites include lead, chromium, arsenic, trichloroethylene, toluene, benzene, cadmium, zinc, tetrachloroethylene, methylene chloride and others. Pathways to exposure include air, soil, water and food. The agency identifies priority health conditions as cancer, kidney dysfunction, lung and respiratory diseases, birth defects and respiratory disorders, immune function disorders, liver dysfunction, and neurotoxic disorders.

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: NO Question Weight: 20%

Explanation: ATSDR is not redundant of the Environmental Protection Agency or the National Institutes of Health, however, the program has administrative and management redundancies with the Centers for Disease Control and Prevention. As is discuss below, CDC and ATSDR have begun to address the issue of administrative redundancy by planning a merger of functions at the office of the director level. Once complete, if this merger eliminates the redundancy, the response to this question will change. There are important programmatic distinctions. ATSDR focuses specifically on toxic substances with expertise in toxicology, risk assessments, sampling, cleanup and other Superfund related activities. CDC's National Center for Environmental Health has a more broad focus and also has laboratory capacity. The program collaborates with private industry to make use of similar research.

Evidence: ATSDR and NCEH focus on environmental health, are part of HHS, share general mission and purpose of protecting the public's health, are in Atlanta and rely on some of the same staff expertise. They have considered consolidation at various times since 1981. ATSDR's budget is smaller than NCEH's and the majority of other CDC's centers. The ATSDR Administrator position and the CDC Director position are occupied by the same individual. In addition to the administrative structure, CDC does support some similar activities and they are engaged in several joint efforts. With respect to EPA, ATSDR is not a regulatory agency and delineates responsibilities through memorandum of understanding, managers forum meetings. NIH conducted $73 million in Superfund related research in FY 2002. A May 2003 memorandum of understanding specifies EPA determines contamination and threats to health and the environment and ATSDR assesses current or future health effects in exposed populations. In the Great Lakes, of the 50 programs focused on the basin, 33 are federally funded, including ATSDR (GAO-03-515).

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: There is no evidence that another approach or mechanism would be more efficient or effective to achieve the intended program purpose. ATSDR addresses the program purpose through a combination of cooperative agreements with States, contracts, and direct federal assessments and other activities for ATSDR staff.

Evidence: ATSDR has cooperative agreements with 23 States to conduct public health assessments at sites where hazardous substances are present, health consultations, health studies and health education. ATSDR has 429 full time equivalent employees in Atlanta, Washington DC and in ten EPA regional offices. Common areas of expertise include toxicologists, epidemiologists, health educators and public health advisors.

Program Assessment Rating Tool (PART)

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

1.5 **Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly?** Answer: YES Question Weight: 20%

Explanation: ATSDR focuses on EPA's 275 priority hazardous substances that are associated with the most serious health impacts. ATSDR also focuses site-specific resources on the Superfund sites on EPA's National Priorities List. Prior to dedicating resources to other sites on the basis of petitions from the public, ATSDR screens requests to focus resources on areas where there is a clear public health need. Petitions come from citizens, city officials, organizations and civic groups and elected officials. ATSDR also uses an evaluation criteria for updating and creating toxicological profiles. ATSDR also responds to acute events and other requests on an ongoing basis. GAO had found inefficiencies in Superfund health assessment requirements (GAO-01-447).

Evidence: The 33 cooperative agreements funded by ATSDR account for 80% of the toxic sites in the United States. The agency uses frequency of occurrence at NPL sites, toxicity and potential for human exposure, including the concentration of substances and the exposure of populations, as the guiding criteria for ranking hazardous substances on their priority list. The procedures ATSDR uses to evaluate petitions for public health assessments from the public and set priorities for action are detailed in the August 18, 1992 Federal Register. Other response activities include acute releases, consultations with other agencies, conferences and technical assistance. Toxicological profiles are summaries of agency evaluations of the levels of exposure at which adverse health effects do and do not occur.

2.1 **Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program?** Answer: YES Question Weight: 12%

Explanation: The program adopted a new long-term outcome measure to capture the impact of the agency on human health in communities potentially exposed to toxic substances. The long-term measure is the percentage of sites where risk/diseases have been mitigated. The measure would compare levels taken at a period after ATSDR's intervention to those taken at the time of the initial site assessment.

Evidence: The measure will capture the reduction in exposure of affected persons. Depending on the toxic substance(s) and routes of exposure, the impact of interventions on human health can be measured in some instances through morbidity and mortality data, such as childhood cancer rates and birth defects. In other cases, such as mesolthelioma resulting from asbestos exposure cancer, the period of time before presence of illness requires other means of measurement. Biomarkers that signal the presence of toxic substances will be used in cases where reliable and affordable tests are available. In cases where no tests or data indicating the impact on human health are available, environmental monitoring may be used. Environmental monitoring could include levels of environmental exposure or documented changes in behavior that are directly linked to exposure.

2.2 **Does the program have ambitious targets and timeframes for its long-term measures?** Answer: NO Question Weight: 12%

Explanation: The new long-term outcome measure will rely on separate indicators for each site. A baseline and target for the percentage of sites where the agency has met the objective has not yet been established.

Evidence: Evidence includes documentation from the agency and the 2005 GPRA plan.

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 12%

Explanation: The program adopted new annual performance measures during the PART process. As included in the measures tab of the worksheet, the measures are: Prevention of ongoing/future exposure and resultant health effects from hazardous waste sites and releases; and Determined human health effects related to exposure to 275 Superfund-related priority hazardous substances. An efficiency measure is not yet available.

Evidence: Evidence includes the draft 2005 GPRA plan and 2003 GPRA report. The first measure captures the objective of by 2006, increasing the percentage of ATSDR's recommendations accepted by EPA, state regulatory agencies, or private industries at sites with documented exposure to over 75%. The second measure captures the objective of by 2006, filling at least 64 additional data needs related to the 275 priority hazardous substances. ATSDR has identified 263 data needs for 60 priority substances. Priority data needs are reassessed every two to three years.

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: The program recently adopted annual performance measures and baselines and targets. The targets are ambitious.

Evidence: Evidence is taken from the agency submission for the PART assessment.

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: Partners receiving cooperative agreements link their proposals and annual plans of work to the agency's broad goals and objectives and to the GPRA plan. External partner organizations also contributed to the development of the Agency's strategic plan for FY 2002-2007. The program adopted new long-term outcome goals and annual goals and has the capacity to require partners to commit to and report on their progress to meeting those goals as well. ATSDR will begin requiring partners to commit to and work toward the newly adopted goals of the program.

Evidence: Evidence includes ATSDR's STARS system, the 2005 GPRA plan and 2003 GPRA report. Program partners include state and local governments, EPA, national organizations, CDC and other federal agencies. Cooperative agreement partners provide detailed annual plans of work and reports that specify dates and types of events and accomplishments.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: YES Question Weight: 12%

Explanation: GAO has produced a number of reports related to ATSDR's health assessments. The most directly related focused on environmental health data needs (GAO/HEHS-00-80). The OIG has not conducted evaluations of ATSDR activities beyond oversight of Superfund expenditures. In 1984 GAO reviewed HHS implementation of Superfund related health activities (GAO/HRD-84-62). Research Triangle Institute and Oak Ridge National Laboratory evaluated the toxicological profile program in 1993. Gallup queried satisfaction with the scientific counsel. While it may not meet the standard for an independent and comprehensive evaluation, the agency's own board of scientific counselors provides feedback on program activities and effectiveness that provides information on program progress. Given the focus and timing of the GAO reports, additional independent and comprehensive evaluations of the impact of agency activities would be useful.

Evidence: GAO reports include GAO/HEHS-00-80, GAO/HRD-84-62.

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: The agency has made significant progress in this area but has not yet reached an integrated development of the program budget and performance information that meets the standards set out for this question. The agency has been developing performance reports to estimate the total cost to support four broad goals. The agency first linked past year funding and FTE to broad goals and objectives in FY 2002. The agency also measures cost of achieving results on goals quarterly. The agency will consider merging the budget justification with the performance plan and report so that the performance measures are integrated into the budget description.

Evidence: Evidence includes the draft 2005 GPRA plan and 2003 GPRA report and the 2004 Congressional Justification. Of the agency's total resources, 70% are appropriated funds and 30% are reimbursable funds. For example, EPA provides ATSDR with funding for a special request or project through an interagency agreement. Superfund funding comes from taxes levied on chemical and petroleum companies and from appropriations. The agency began receiving a direct appropriation in FY 2001. ATSDR also uses their planning process to estimate the number and contribution agency FTEs make to achievement of the overall strategy. ATSDR expenses at a health assessment or health effects study can be recovered from potentially responsible parties by law. The agency's GPRA performance plan identifies the agency's total resources, Superfund resources and full time equivalent employees associated with each of the agency's four overarching goals for the prior budget year. Resources include salary and benefits.

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: The program has adopted new performance measures and is continuing work to fully develop the new long-term outcome measure on the impact of agency efforts on the health of persons affected by toxic substances at sites. The program is also incorporating additional accountability in the agency by extending performance into managers below the SES level. The agency is also working to develop a budget justification that will allocate total funding by each discrete performance indicator and reflect the performance level associated with each increment of funding.

Evidence: Evidence includes the 2005 GPRA plan and 2003 GPRA report, agency planning documents.

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 10%

Explanation: The program collects semi-annual reports from cooperative agreement partners to assess performance against established annual plans of work. Internally, the agency reports results on a performance management framework that are evaluated on a quarterly basis. The agency assigns leads or champions for performance indicators that are tracked and are specific to each division. Where agency performance did not meet expectations in 2002, the agency reports making changes in resource application the following year. Technical reviewers provide detailed feedback to agency grantees in performance evaluations that specify recommended actions and areas of needed improvement. These reviews also provide a review and response to grantee requests for additional funding. The agency also uses pre-and post-tests to determine the effectiveness of environmental health training activities.

Evidence: Evidence includes state cooperative agreement evaluation reports, summaries of partners meetings, and agency summary documents.

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

3.2 Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?

Answer: YES Question Weight: 10%

Explanation: Senior ATSDR program managers are responsible for cost and schedule outcomes and performance results. Senior executive service managers, such as the deputy assistant administrator and the associate administrator for urban affairs, have performance-based contracts. Program partners are held accountable for cost, schedule and performance results. Non-SES program managers do not have performance-based contracts or personnel evaluations that consider program performance. Agency divisions identify discrete near, mid and long-term targets by specific program areas.

Evidence: Evidence includes the performance plans of senior managers, progress reports and program evaluation documents for grantees.

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?

Answer: YES Question Weight: 10%

Explanation: ATSDR generally obligates funds by the end of the year and there is no indication funds are not spent for the intended purpose. ATSDR has mechanisms to ensure partners spend funding for the intended purpose. The HHS Office of the Inspector General has found the agency administered Superfund resources appropriately by statute and regulation. Auditor reports have found needed corrections such as in the charging of salaries to branches.

Evidence: Evidence includes summary documents of end of year balances, OIG reports (e.g., CIN-A-04-98-04220), annual budget submissions and financial reports, monthly progress reports and agency grants management procedures.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?

Answer: YES Question Weight: 10%

Explanation: The agency is entering into a review with CDC's National Center for Environmental Health on merging administrative functions of the two entities to improve efficiency and reduce redundancy. A statement of intent has been signed by ATSDR and CDC and endorsed by the department that proposes the administrative and management consolidation. The program also uses efficiency measures for administrative staff. ATSDR also provides funding to CDC for administrative and support services and on a lesser basis for shared grants and other programmatic activities. The agency is converting toxicological profiles to CD-ROM. The agency has begun using an internet based system for cooperative agreements. The program provides personal digital assistants to regional staff in the field with toxicological profiles, medical management guidelines and other data to improve efficiency and timeliness and reports the technology has made field staff more efficient. The program provides continuing education on the internet.

Evidence: Evidence includes planning documents for the administrative level merger with CDC and the interagency agreement between ATSDR and CDC, including a statement of work and statement of intent, the December 2000 "Shared Vision for Environmental Public Health at CDC/ATSDR," summary graphs on administrative staff efficiency, quarterly workforce restructuring updates for consolidation and de-layering activities and summary descriptions of field staff technology. Areas of study for the consolidation include budget, personnel, travel, health communications, media relations, policy, planning and evaluation, legislative affairs, publishing and other administrative and support functions. The Pew Environmental Health Commission also recommended consolidation with NCEH.

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 10%

Explanation: ATSDR collaborates extensively with the Centers for Disease Control and Prevention, especially CDC's National Center for Environmental Health. Other federal agencies ATSDR collaborates with include EPA, the Federal Emergency Management Agency, the Department of Justice, the Department of Interior, the Department of Agriculture, the Department of Defense, the Department of Energy, the National Institutes of Health, the World Health Organization, New York City and other entities. ATSDR uses memoranda of understandings with many of these entities. ATSDR also collaborates with state and local public health organizations on site assessments and other efforts. An EPA and ATSDR managers forum is in place specifically to address program management and other common interests related to Superfund. The meetings are held in regions and can cover regional topics, new issues and site specific activities. ATSDR collaborates with industry through the agency's Voluntary Research Program.

Evidence: Evidence includes memorandum of understanding with CDC, Interior, Energy, EPA, Agriculture, PAHO, WHO, interagency agreements, quarterly reports and managers forum minutes. The EPA documents specify the two entities should work collaboratively at the national level to minimize differences in reported conclusions on the degree of risk to human health at a given site. An ongoing example of collaboration includes ATSDR's meeting with EPA, the Mine Safety and Health Administration, the Occupational Safety and Health Administration, the National Institute for Occupational Safety and Health, the U.S. Geological Survey and the National Institute of Standards and Technology quarterly since September 2002 on asbestos (GAO-03-469). GAO found RAND's work on Gulf War illness was not coordinated with IOM or ATSDR (GAO/NSIAD-00-32).Beginning in August of 2000, ATSDR and CDC's National Center for Environmental Health under the leadership of the director developed a plan for a comprehensive environmental public health program and associated strategies for the two agencies.

3.6 Does the program use strong financial management practices? Answer: NO Question Weight: 10%

Explanation: CDC's financial statements include ATSDR. The FY 2002 report noted reportable conditions relating to information systems; the internal controls over preparation, analysis and monitoring of financial information, including manually intensive procedures; reimbursable agreements; and grants accounting and oversight. None of the reportable conditions are considered material internal control weaknesses. CDC has actively addressed key areas. CDC automated reimbursable billings, enhanced year end closing transactions and implemented a new indirect cost methodology. CDC is also addressing staffing needs, including core accounting competencies, professional staff recruitment, financial systems, training and customer service. ATSDR contracted the development of an indirect cost allocation methodology to be similar to CDC's system. The report found ATSDR's records and cost recovery system were sufficient to allocate costs, but could be improved. The OIG confirmed ATSDR properly accounted for Superfund resources. EPA and ATSDR agreed to principles and worked to improve cost recovery practices.

Evidence: Evidence includes the FY 2002 Chief Financial Officers annual report, including summary of reportable conditions, summary documents on end of year balances, OIG reports (e.g., CIN-A-04-98-04220), a report on indirect cost allocations from Capital Consulting Corporation, ATSDR and EPA region ten memorandum on site activities and cost recovery efforts. Four areas of findings were also documented the prior year. CDC has received five consecutive unqualified opinions on the agency's financial statements. Additional data include that CDC issued 64 duplicate or erroneous payments in FY 2002, or 0.042% of all payments and has a 97% compliance rate for prompt payments. ATSDR indirect costs are capped at 7.5%.

Program Assessment Rating Tool (PART)

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 10%

Explanation: CDC/ATSDR is continuing to make improvements to financial management processes, including restructuring its budget and financial accounting system to more accurately track expenditures and hiring a consulting firm to develop a more consistent and accurate system for charging overhead. CDC initiated changes in core accounting competencies, professional staff recruitment, financial systems training, and customer service. CDC commissioned a business case for timelines, cost estimates and functional and technical solutions. CDC/ATSDR will transition to HHS Unified Financial Management System and will automate the financial accounting processes. ATSDR will be using additional performance contracts for all senior managers in 2003 to include program performance. ATSDR is reclassifying additional positions from administrative to front line health positions and changed positions from supervisory to non-supervisory to eliminate smaller organizational units as part of a de-layering effort. The agency has taken no steps to make grantee performance data available to the public.

Evidence: Evidence includes submissions from ATSDR, an internal evaluation of strike team responses, the public health assessment enhancement initiative final report. CDC/ATSDR will be the first to pilot HHS Unified Financial Management System in October 2004. CDC/ATSDR launched a technical team and business transformation team to implement new procedures and improve their process. CDC/ATSDR added reimbursable agreements as an automated system. To improve agency operations, the program initiated a public health assessment enhancement initiative to integrate agency efforts with EPA's Superfund process and set up a team of environmental health scientists to improve the quality and timeliness of responses to requests for technical assistance from EPA, state and local governments and other entities. The agency is phasing in external scientific merit reviews for all extramural research awards by October 1, 2005.

3.CO1 Are grants awarded based on a clear competitive process that includes a qualified assessment of merit? Answer: YES Question Weight: 10%

Explanation: Applications for cooperative agreements are competitively awarded based on clear criteria. Awards are made based on merit and eligibility. There are few one-year, non-competitive earmarks. The agency establishes an independent review group to evaluate each application against specified criteria. Grantees are typically state and local governments (including territories) and political subdivisions of states such as state universities, colleges and research institutions.

Evidence: Evidence includes grant review procedures from the agency and Federal Register notices of the availability of funds. Approximately 54% of ATSDR's budget is distributed through contracts, grants, cooperative agreements and interagency agreements.

3.CO2 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: YES Question Weight: 10%

Explanation: Technical Project Officers monitor performance and work with grantees to take corrective action as needed. As noted above, technical reviewers provide detailed feedback to agency grantees in performance evaluations that specify recommended actions and areas of needed improvement.

Evidence: Evidence includes state cooperative agreement evaluation reports and agency summary documents.

Program Assessment Rating Tool (PART)

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

3.CO3 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: NO Question Weight: 10%

Explanation: The agency collects grantee performance information but does not make the information available to the public. Performance information is aggregated at a high level and made public on the agency's website through the GPRA performance reports. The program does provide educational materials, public health assessments, health consultations and health studies from program partners on the internet.

Evidence: Evidence includes the agency web site (www.atsdr.cdc.gov) and the 2002 GPRA performance report.

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: NO Question Weight: 25%

Explanation: As noted in Section II, the program adopted a new long-term outcome measure to capture the impact of the agency on human health in communities potentially exposed to toxic substances, but does not yet have a baseline and data to show progress on this measure.

Evidence: The long-term measure is the percentage of sites where risk/diseases have been mitigated. The agency has a well established system for performance planning and measuring progress on specific objectives both internally and with the program partners. Once a measure is adopted, the agency will be in a good position to track progress against specific long-term health outcomes.

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: LARGE EXTENT Question Weight: 25%

Explanation: The agency has adopted new annual performance measures and based on past performance is making progress on those targets. A Large Extent is given because two years of data are available that indicate accomplishments. The program has adopted a new long-term outcome measure and also received a Yes in question five of Section II regarding partner commitment and contributions to the agency's measures.

Evidence: Evidence includes accomplishment in filling data gaps and a general increase in the percentage of recommendations that have been accepted.

4.3 **Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** Answer: LARGE EXTENT Question Weight: 25%

Explanation: Over the past year, the program dissolved the Office of Federal Programs and reduced the number of branches within the Division of Health Education and Promotion. The agency converted the 40,000 page Toxicological Profiles from paper to CD-ROM and the Internet. The program is creating a web-based system for HazDat hazardous substances database and for the cost recovery system. A cost savings estimate for this conversion is not available. ATSDR's Voluntary Research Program allows commercial partners to provide toxicological data needed by the program. The proposed administrative consolidation with the National Center for Environmental Health has the potential to further improve efficiencies and cost effectiveness by focusing more agency staff on programmatic activities.

Evidence: Evidence includes agency documentation of de-layering efforts, documents on the proposed consolidation, memorandum of understanding for the voluntary research program and related findings, such as on the impact of methylene chloride on human immune system. The toxicological profiles are now provided to 3,000 interested parties in 47 countries. ATSDR estimates the Voluntary Research Program has saved the agency an estimated $5 million in reduced costs.

Program Assessment Rating Tool (PART)

Program: Agency for Toxic Substances and Disease Registry
Agency: Department of Health and Human Services
Bureau: Agency for Toxic Substances and Disease Registry
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	80%	42%	

4.4 **Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?**

Answer: NA Question Weight: 0%

Explanation: There are no programs with similar programmatic goals for comparison. As noted in section one, the program shares mission and procedures with CDC, however, the program is supporting distinct efforts with a unique set of desired objectives. While state and local health departments support some of the same activities, the role of the federal agency in this case is largely unique.

Evidence: Evidence includes agency budget reports, GAO-03-469 Hazardous Materials for an example of division of responsibilities for asbestos work in Libby, Montana, authorizing legislation, and memorandum of understanding described in section III above.

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?**

Answer: SMALL EXTENT Question Weight: 25%

Explanation: Select GAO reports on ATSDR activities have described agency accomplishments and generally found the agency is effective in meeting the program purpose. Small extent is given because the reports shed light on the program's impact but were not primarily focused on the effectiveness of the program and do not provide a full picture of program performance. Reviews have focused on Superfund, asbestos contamination in and related to Libby, Montana, and broad reports in which ATSDR was one of many federal agencies. In varying degrees, the reports consider program effectiveness. One report concluded a limited number of ATSDR investigations with human exposure data are available given the number of Superfund sites. The OIG also reports on the programs financial management with respect to Superfund and has found the agency manages the resources effectively. Gallup's evaluation of the ATSDR Board of Scientific Counselors in February 2003 found committee stakeholders are satisfied with the board make-up and operations. A 1993 RTI review identified program strengths and detailed recommendations.

Evidence: The 1999 GAO review on Superfund reported EPA found ATSDR's products and services were useful for cleaning up hazardous waste sites, especially EPA requested consultations on health concerns unique to a site. GAO reported, however, the assessments "had little or no impact on EPA's cleanup decisions" because of problems with timeliness and specificity (GAO/RCED-99-85; GAO-01-447). A GAO review on measuring human exposures to toxic chemicals notes the relative shortage of assessments. The report describes the agency's efforts in aiding states and residents, but noted the need for better coordination between EPA, CDC and ATSDR (GAO/HEHS-00-80). GAO reviews of efforts in Libby, Montana (GAO-03-469) and Washington DC (GAO-02-836T) describe ATSDR's efforts and accomplishments. A 1984 GAO review cited EPA funding delays and reductions and HHS staffing limitations as the reason for slow progress (GAO/HRD-84-62). GAO found lead poisoning programs are not reaching at risk children, but the report did not focus on ATSDR (GAO/HEHS-99-18). An OIG report example is CIN-A-04-98-04220.

PART Performance Measurements

Program: Agency for Toxic Substances and Disease Registry

Agency: Department of Health and Human Services

Bureau: Agency for Toxic Substances and Disease Registry

Measure: Prevention of ongoing and future exposure from hazardous waste sites and releases and the associated human health effects, as measured by the percentage of ATSDR's recommended actions EPA, States, or industry follow at sites with documented exposure.

Additional Information: By 2006, increase the percentage of ATSDR's recommendations accepted by EPA, State regulatory agencies, or private industries at sites with documented exposure to over 75%.

Year	Target	Actual	**Measure Term:** Annual
2001		53%/114K people	
2002		51%	
2003	55%		
2004	60%		
2005	70%		

Measure: Discovery of the human health effects of exposure to 275 Superfund-related priority hazardous substances, as measured by filling additional data needs related to these substances.

Additional Information: By 2006, fill at least 64 additional data needs related to the 275 priority hazardous substances.

Year	Target	Actual	**Measure Term:** Annual
2001		9	
2002		6	
2003	6		
2004	10		
2005	15		

PART Performance Measurements

Program: Agency for Toxic Substances and Disease Registry

Agency: Department of Health and Human Services

Bureau: Agency for Toxic Substances and Disease Registry

Measure: Percentage of sites where human health risks and disease have been mitigated, as measured by testing in blood levels, cancer rates, other morbidity and mortality data, levels of environmental exposure and other methods.

Additional Information: Measures the impact on human health by determining the continued level of exposure through testing such as exposure in blood levels, cancer rates and other morbidity and mortality data, levels of environmental exposure and other methods.

Year	Target	Actual
2003		

Measure Term: Long-term

Program Assessment Rating Tool (PART)

Program: CDC State and Local Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	63%	56%	26%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The purpose of these grants are to improve state and local public health capacity to respond to terrorist attacks and emergencies, in the event of a biological, chemical or radiological/nuclear attack.

Evidence: (1) Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107-188) (2) Funding provided in 2001 Emergency Supplemental Appropriation (Public Law 107-38), 2003 Consolidated Appropriations Act (Public Law 108-7)

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The need to improve state and local preparedness remains. The risk of attack was made clear on September 11, 2001 and the subsequent anthrax attack in the fall of 2001. Recent reports indicate that gaps exist in the public health infrastructure's ability to respond to such attacks and emergencies.

Evidence: (1) GAO Report 03-373, "Bioterrorism: Preparedness Varied across State and Local Jurisdictions" (2) GAO-03-769T, testimony before the Subcommittee on Oversight and Investigations (3) GAO Report 02-149T, "Bioterrorism: Review of Public Health Preparedness Programs" (4) GAO Report 02-141T, "Public Health and Medical Preparedness" (5) Association of Public Health Laboratories June 2003 report, "Public Health Laboratories, Unprepared and Overwhelmed" - http://healthyamericans.org/resources/files/LabReport.pdf (5) IOM - "Biological Threats and Terrorism: Assessing the Science and Response Capabilities" http://books.nap.edu/books/0309082536/html#pagetop

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: There is some natural overlap since there are a number of programs that exist to improve national preparedness against terrorist attacks. However, this is the only program with the explicit purpose of improving state and local public health capacity. In addition, CDC has worked to coordinate with other agencies performing related missions, both within and outside of HHS. These include the Department of Homeland Security, and the Health Resources and Services Administration.

Evidence: HHS has taken steps to ensure coordination within the Department, with the Assistant Secretary for Public Health and Emergency Preparedness taking a strong role in coordinating HRSA and CDC efforts in this area. This includes joint grant announcements, and simultaneous release of funding, and cross-references in HRSA and CDC cooperative agreements. In addition, HHS has entered into a Memorandum of Agreement with DHS on related/shared responsibilities.

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: There is no evidence that a different design would be more effective. CDC approves each state's planned use of these funds, ensuring that they are used to improve public health preparedness/response capacity. CDC will not approve state budgets that supplant other funding sources. CDC conducts monitoring/oversight visits to state programs, which include fiscal review.

Evidence: Cooperative Agreement guidance

Program Assessment Rating Tool (PART)

Program: CDC State and Local Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	63%	56%	26%	

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: NO Question Weight: 20%

Explanation: Funds are distributed through a Congressionally established formula that provides every state with a base amount, and the remainder through a population factor. This design ensures that every state can make some preparedness improvements, while larger states receive greater assistance. However, this design is not optimal past the short term. Currently, most states have great need and can put the base amount to good use, but this will not always be the case. In addition, population is not an exact proxy for need of assistance. To avoid an automatic provision of scarce resources to states with lesser need, assessments should be done to determine each state's preparedness compared to its need. Funding should be distributed to states according to their need for assistance, and demonstrated ability to use funds to make the required improvements. Otherwise, the program can not be accurately described as effectively targeted.

Evidence: (1) Cooperative Agreement guidance (2) Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107-188)

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation:

Evidence: see Measures tab

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation:

Evidence: see Measures tab

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: YES Question Weight: 12%

Explanation:

Evidence: see Measures tab

2.4 Does the program have baselines and ambitious targets for its annual measures? Answer: YES Question Weight: 12%

Explanation:

Evidence: see Measures tab

Program: CDC State and Local Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	63%	56%	26%	

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: States and other partners are committed to the annual and long-term goals of the program, as established in cooperative agreements.

Evidence: (1) CDC State Local Preparedness Cooperative agreement guidance (2) cooperative agreements have also been entered into with additional partners, including (ASTHO, NACCHO, CSTE and APHL) to work toward annual/long term goals of the program.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: NO Question Weight: 12%

Explanation: There have been no comprehensive independent evaluations of the program that would lead to program improvements. CDC requested that the HHS IG, Office of Evaluations and Inspections review the program.

Evidence:

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: Congressional Justification materials do not identify spending categories in sufficient detail. Further, since states determine allocation of total funding, CDC can not tie funding levels to achievement of specific goals.

Evidence: FY 2001 - FY 2004 CDC Congressional Justifications. Cite cooperative agreement

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: NO Question Weight: 12%

Explanation: There are no plans as of yet for independent evaluations.

Evidence:

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 11%

Explanation: CDC requires funding recipients to submit semi-annual progress reports, project officers conduct site visits, and while there is not enough experience yet with this program to demonstrate full use of performance data to improve future program performance, these reporting mechanisms and CDC staff activities are designed to acheive that end.

Evidence: (1) Financial Status Reports are ue 90 days after end of fiscal year. (2) CDC Project Officers conduct site visits, with resulting reports that include recommendations to states. (3) States were initially awarded funds by specific focus area, but as a result of semi-annual report, current guidance provides a process for managing redirection between focus areas, or carryover from one fiscal year to the next.

Program: CDC State and Local Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	63%	56%	26%	

3.2 Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results? Answer: NO Question Weight: 11%

Explanation: There are no current mechanisms in use to incorporate program performance into federal managers performance evaluation criteria.

Evidence: Performance contracts are not used.

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 11%

Explanation: Federal funds from this program have been obligated in an extremely timely manner. State obligations have been less timely, in large part due to the major increase in funding level, and subsequent ramp-up in state expenditures. CDC ensures that funds are used for their intended purposes.

Evidence: (1) Federal funds were appropriated on January 10, 2002 and 20% were released by CDC to state by February, with the remainder released in June, 2002. (2) State spending reports will be available 90 days after end of FY2002, but current estimates indicate that 94% will be obligated by end of FY2002. (3) All funding requests are reviewed for consistency with program purpose. Any inconsistent requests are disallowed. All post-award budget changes must be approved by CDC.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: NO Question Weight: 11%

Explanation: While CDC does take some steps to promote efficiencies, without efficiency goals included in their strategic planning and performance plans, other steps are insufficient.

Evidence: Performance measures do not include any efficiency goals. While CDC does take steps to promote efficiency, including project officer review of funding requests for cost effectiveness, ensuring that states follow their own procuremnt regulations with these funds, and allowing states to purchase items with grant funds through large scale federal procurements as appropriate -- these steps are secondary and insufficient without a focus on cost-effectiveness and efficiency in strategic and performance planning.

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 11%

Explanation: This program, along with HRSA Hospital Preparedness has been an example of coordination within HHS. CDC has also taken actions to coordinate with DHS programs with similar focus, including the Office of Domestic Preparedness.

Evidence: HHS has taken steps to ensure coordination within the Department, with the Assistant Secretary for Public Health and Emergency Preparedness taking a strong role in coordinating HRSA and CDC efforts in this area. This includes joint grant announcements, and simultaneous release of funding, and cross-references in HRSA and CDC cooperative agreements. In addition, HHS has entered into a Memorandum of Agreement with DHS on related/shared responsibilities.

Program Assessment Rating Tool (PART)

Program: CDC State and Local Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	63%	56%	26%	

3.6 Does the program use strong financial management practices? Answer: NO Question Weight: 11%

Explanation: The FY 2002 report noted reportable conditions relating to information systems; the internal controls over preparation, analysis and monitoring of financial information, including manually intensive procedures; reimbursable agreements; and grants accounting and oversight. None of the reportable conditions are considered material internal control weaknesses. CDC has actively addressed key areas. CDC automated reimbursable billings, enhanced year end closing transactions and implemented a new indirect cost methodology. CDC is also addressing staffing needs, including core accounting competencies, professional staff recruitment, financial systems, training and customer service.

Evidence: Evidence includes the FY 2002 Chief Financial Officers annual report, including summary of reportable conditions, summary documents on end of year balances, OIG reports (e.g., CIN-A-04-98-04220). Four areas of findings were also documented the prior year. CDC has received five consecutive unqualified opinions on the agency's financial statements. Additional data include that CDC issued 64 duplicate or erroneous payments in FY 2002, or 0.042% of all payments and has a 97% compliance rate for prompt payments.

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 11%

Explanation: CDC has made and is continuing to make improvements to financial management processes, including restructuring its budget and financial accounting system to more accurately track CDC's expenditures and hiring a consulting firm to develop a more consistent and accurate system for charging overhead. CDC initiated changes in core accounting competencies, professional staff recruitment, financial systems training, and customer service. CDC will transition to HHS Unified Financial Management System and will automate the financial accounting processes. Also, responsibility for the cooperative agreement was moved to the Office of the Director of CDC in October 2002. This move was designed to improve coordination of program activities within CDC and to centralize management of the activities related to this cooperative agreement.

Evidence: CDC will be the first to pilot HHS Unified Financial Management System in October 2004. CDC launched a technical team and business transformation team to implement new procedures and improve their process. Creation of Office of Terrorism Preparedness and Response within the Office of the Director. Also see (3) in evidence for question 3.1

3.BF1 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: YES Question Weight: 11%

Explanation: Cooperative agreement guidance requires semi-annual reporting on activities in each focus area. CDC project officers also conduct site-visits and regular conference calls with grantees.

Evidence: Cooperative Agreement guidance

3.BF2 Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner? Answer: NO Question Weight: 11%

Explanation: Information is collected on a semi-annual basis, but not necessarily made available to the public due to sensitivity/security concerns. Greater effort could be made to summarize non-sensitive information and release progress reports to the public for this magnitude of investment.

Evidence: Information deemed sensitive by CDC legislative counsel.

Program Assessment Rating Tool (PART)

Program: CDC State and Local Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	63%	56%	26%	Results Not Demonstrated

4.1 Has the program demonstrated adequate progress in achieving its long-term performance goals? Answer: SMALL EXTENT Question Weight: 20%

Explanation: Some results have been demonstrated. However, since the program is relatively new, and the performance goals have just been agreed to this year, progress demonstrated does not exceed small extent.

Evidence: Examples from the FY 2002 Progress Report include: (1) Prior to 2002, no states had a smallpox response plan - 42% of states have now developed both pre-event and post-even smallpox response plans. (2) 45 states have developed reportable disease surveillance systems. (3) Many (?) states have reported that their laboratories can now test for 4 of the 5 Category A agents. (4) 67% of grantees have developed an epidemiologic response plan that addresses surge capacity, delivery of mass prophylaxis and immunizations. (5) 91% of grantees can initiate a field investigation 24/day, 7 days/week in all parts of their state within 6 hrs of receiving an urgent disease report.

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: SMALL EXTENT Question Weight: 20%

Explanation: Some results have been demonstrated. However, since the program is relatively new, and the performance goals have just been agreed to this year, progress demonstrated does not exceed small extent.

Evidence: see above. Long-term and annual goals are aligned.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: SMALL EXTENT Question Weight: 20%

Explanation: Performance measures do not include any efficiency goals. However, a number of other choices made regarding program management/structure include attempts at efficiency and cost-effectiveness.

Evidence: See Measures tab. Other steps promoting efficiency and cost effectiveness include promotion of distance learning through Health Alert Network, Regional approach to Laboratory Response Network rather than equipping every laboratory in a sometimes redundant fashion, and the institution of an electronic application.

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: SMALL EXTENT Question Weight: 20%

Explanation: There is not a large body of evidence of progress compared with similar programs such as first responder grants from DHS, or hospital preparedness grants from HRSA. However, given that this cooperative agreement is relatively new, the progress that has been demonstrated indicates initial performance levels that are, to some extent, favorable as compared with other programs.

Evidence: No evidence provided of comparison between the DHS Office of Domestic Preparedness first responder grants and this program. HRSA program is very new, and there is insufficient performance information to make a fair comparison. However, the initial progress demonstrated (see above) are all accomplishments that would not have been achieved without this program. Therefore, at least to some extent, it is performing favorably compared to programs with similar purpose and goals.

Program: CDC State and Local Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	63%	56%	26%	Results Not Demonstrated

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?

Answer: NO Question Weight: 20%

Explanation: Independent evaluations have not yet taken place.

Evidence:

PART Performance Measurements

Program: CDC State and Local Preparedness Grants

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Percentage of LRN laboratories that report routine public health testing results through standards-based electronic disease surveillance systems, and have protocols for immediate reporting of Category A agents.

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2005	75%			
2006	80%			
2007	85%			
2008	90%			

Measure: Percentage of states in whcih properly-equipped public health emergency response teams are on-site within four hours of notification by local public health official, to assess the public health impact, and determine/initiate the appropriate public health intervention, in response to Category A agents.

Additional Information:

Year	Target	Actual	**Measure Term:**	Long-term
2010	100%			

Measure: Percentage of states in whcih properly-equipped public health emergency response teams are on-site within four hours of notification by local public health official, to assess the public health impact, and determine/initiate the appropriate public health intervention, in response to Category A agents.

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2005	75%			
2006	80%			
2007	85%			
2008	90%			

PART Performance Measurements

Program: CDC State and Local Preparedness Grants

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Percentage of state public health agencies that 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 indentified

Additional Information:

Year	Target	Actual	**Measure Term:**	Long-term
2010	100%			

Measure: Percentage of state public health agencies that 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 indentified

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2005	75%			
2006	80%			
2007	85%			
2008	90%			

Measure: Percentage of state health departments certified by CDC as prepared to receive material from the Strategic National Stockpile, and distribute that material in accordance with public health response plans.

Additional Information:

Year	Target	Actual	**Measure Term:**	Long-term
2010	100%			

Measure: Percentage of LRNs the pass proficiency testing for agents on the CDC's Category A threat list

Additional Information: Proficiency standards are established in LRN guidelines. Agents include: bacillus anthracis, yersina pestis, Francisilla tularensis, Clostridium, botlulinum toxin, variola major, vaccinia and varicella.

Year	Target	Actual	**Measure Term:**	Long-term
2010	100%			

PART Performance Measurements

Program: CDC State and Local Preparedness Grants

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Percentage of Laboratory Response Network labs that pass proficiency testing for Category A threat agents

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2005	75%			
2006	80%			
2007	85%			
2008	90%			

Measure: Percentage of states with level 1 chemical lab capacity, and agreements with/access to a level 3 chemical lab (specimens arriving within 8 hours)

Additional Information: This measure requires 1 level-1 chemical lab in every state, and access to a level-3 equipped to detect exposure to nerve agents, mycotoxins and select industrial toxins.

Year	Target	Actual	**Measure Term:**	Long-term
2010	100%			

Measure: Percentage of states with level 1 chemical lab capacity, and agreements with/access to a level 3 chemical lab (specimens arriving within 8 hours)

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2005	75%			
2006	80%			
2007	85%			
2008	90%			

PART Performance Measurements

Program: CDC State and Local Preparedness Grants

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Percentage of state/local public health agencies in compliance with CDC recommendations for using standards-based, electronic systems for public health information collection, analysis and reporting.

Additional Information:

Year	Target	Actual	**Measure Term:**	Long-term
2010	100%			

Measure: Percentage of state/local public health agencies in compliance with CDC recommendations for using standards-based, electronic systems for public health information collection, analysis and reporting.

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2005	75%			
2006	80%			
2007	85%			
2008	90%			

Measure: Percentage of LRN laboratories that report routine public health testing results through standards-based electronic disease surveillance systems, and have protocols for immediate reporting of Category A agents.

Additional Information:

Year	Target	Actual	**Measure Term:**	Long-term
2010	100%			

Program Assessment Rating Tool (PART)

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The purpose of the Children's Hospitals Graduate Medical Education Payment Program (CHGME PP) is to provide funds to free-standing children's hospitals. The program does not explicitly support teaching activities because the children's hospitals can utilize the subsidy for any purpose

Evidence: Section 340E of the Public Health Service Act provides the formula for determining payments to children's hospitals, similar to how Medicare reimburses teaching hospitals. Payments are allocated among the participating children's hospitals according to the number of residents at each participating hospital, a hospital's case mix, average length of stay, and the number of beds. The number of residents a hospital is allowed to claim is capped at 1996 levels. The authorizing statute and regulations do not stipulate what activities hospitals may use CHGME funds for. In FY2002, 59 children's hospitals received payments totaling $276 million.

1.2 Does the program address a specific and existing problem, interest or need? Answer: NO Question Weight: 20%

Explanation: Children's hospitals receive GME funding from a number of sources besides the CHGME PP. Federal and state Medicaid funds, private insurance, and charity donations pay for GME in children's hospitals. Medicaid is budgeted to pay $2.1 billion in direct Federal GME payments in FY2003. Children's hospitals receive limited Medicare GME funds because very few of their patients are enrolled in Medicare. Medicare reimburses hospitals for GME because Medicare pays for services used by its beneficiaries, including GME costs. CHGME PP is not purchasing services for enrollees in a health planit is providing a general subsidy to children's hospitals. Children's hospitals are more likely to have positive margins than other hospitals, including teaching hospitals. In 1999, 25% of CHGME PP eligible children's hospitals had negative margins. In 1999, 34% of all hospitals and 43% of major teaching hospitals had negative margins. In 2000, 26% of children's hospitals had negative margins and 33% of all hospitals and 41% of major teaching hospitals had negative total margins.

Evidence: According to a 1998 survey conducted by the National Conference of State Legislatures, nearly all states in which medical schools are located make some level of special payments to teaching hospitals under the Medicaid program.GPRA reports provided children's hospital margins data and MedPac's "Annual Report to Congress: Medicare Payment Policy" provided hospital margins data. In 2001, 21% of children's hospitals had negative margins. We do not have reliable margins data on hospitals other than children's hospitals for 2001.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: NO Question Weight: 20%

Explanation: Children's hospitals receive GME funding from sources besides the CHGME PP, including Medicaid, private insurers, and charitable donations. Children's hospitals receive roughly 45% of their patient care revenue from Medicaid. Medicaid will spend $2.1 billion in direct federal GME payments in FY2003. These payments do not account for special payment rates to children's hospitals or GME payments not explicitly formulated. In addition, HRSA's Training in Primary Care and Medicine and Dentistry grants provide funding for pediatric residents training. In FY2002, the program awarded $11.6 million in grants for General Pediatrics and Pediatric Dentistry. As of June 2003, the program had awarded $10.0 million in FY2003 grants for General Pediatrics and Pediatric Dentistry. This program has no budgetary request for FY2004, but currently constitutes a revenue stream for training pediatric residents.

Evidence: In 2001, children's hospitals received 45% of their gross revenue from patient care attributed to Medicaid, Medicare, and uninsured patients. Medicaid constituted the bulk of this revenue since payments from Medicare and uninsured patients is limited in children's hospitals. According to a 1998 survey conducted by the National Conference of State Legislatures, nearly all states in which medical schools are located make some level of special payments to teaching hospitals under the Medicaid program.

Program Assessment Rating Tool (PART)

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: NO Question Weight: 20%

Explanation: The program pays children's hospitals CHGME funds in a timely and accurate manner. However, by statute, the program pays children's hospitals on a bi-weekly basis. The program could improve efficiency by paying hospitals on a quarterly basis.

Evidence: Public Health Service Act Section 340E requires that eligible hospitals receive bi-weekly payments.

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: The intended beneficiaries of this program are children's hospitals. The formula and program processes require that the eligible hospitals receive the correct payment on a bi-weekly basis. The authorizing legislation lists eligibility requirements and the program reevaluates eligibility each year. Program data indicates that currently all eligible children's teaching hospitals that have applied are receiving CHGME PP funding.

Evidence: Public Health Service Act Section 340E stipulates the payment formula. The March 1, 2001 Federal Register notice outlines the implementation of the payment formula. A press release detailing the funding level for each hospital is released at the end of the fiscal year.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation: The program adopted new long-term goals during the assessment process. The long-term measures focus on improving the accuracy of data used to compute payments to hospitals. CHGME will verify FTE resident counts and caps, and will verify bed counts, case-mix indices, and number of discharges reported by hospitals, contingent on the results of a pilot study to be implemented in FY 2006. The program is currently working to improve the accuracy of a key payment formula data element: full-time equivalent (FTE) resident counts. In FY2003, the program, under a contract with Blue Cross Blue Shield Association, assessed the FTE resident cap reported by each of the hospitals applying for funds as well as the weighted and unweighted FTE resident counts for each of the three Medicare Cost Report years used to determine the weighted and unweighted rolling averages. The weighted rolling average is used to determine DME payments and the unweighted rolling average is used to determine the IME payments.

Evidence: The program has two long-term measures: 1) Verify all hospitals bed counts, case-mix indices, and number of discharges contingent on the results of pilot studies to be implemented in 2006; 2) Verify all hospitals FTE resident counts and caps.

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation: The program has adopted ambitious targets for its long-term goals. The program allocates funds to individual hospitals on a proportionate basis. A reporting error in one hospital may affect the size of allocations to all hospitals. Therefore, it is important to verify data provided by all hospitals. The program's annual goals will allow the program to achieve the long-term targets.

Evidence: The program has targets for each of its long-term goals: 1) Contingent upon theresults of pilot studies, verify 100% of hospitals reported data on bed counts,case-mix index, and number of discharges in FY2008; 2) Beginning withFY 2003, verify 100% of hospital FTE resident counts and caps.

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 12%

Explanation: During the assessment process, the program adopted new annual performance measures that demonstrate progress towards long-term goals. These goals are to ensure all payments are made on time and to verify the accuracy of data used to compute payments.

Evidence: CHGME PP annual goals measure: 1) The percentage of payments to hospitals made every 2 weeks or 1month, as appropriate, throughout the fiscal year, subject to availability of funds and factors outside of programmatic control. Monthly payments are made early in each fiscal year during the period when final program allocations are being determined (This includes any continuing resolution); 2) Verification of all hospitals FTE resident counts and caps; 3) Actions to assess the feasibility and cost effectiveness of verification of all hospitals bed counts, case-mix indices, and number of discharges used in the final determination of payments.The program is not currently auditing each hospital's bed counts, case-mix indices and discharges. Achieving this goal will require intermediate steps before program-wide changes can be implemented, including: 1) Develop methodologies for verifying case-mix indices, bed counts, and number of discharges, and estimate costs of verification; 2) Pilot test the methodologies to ensure their feasibility and cost effectiveness, and 3) Contingent upon the results of pilot studies, develop a Federal Register notice and analyze comments; and 4) Contingent upon the results of pilot studies and responses to the Federal Register notice, implement additional verification procedures for case-mix index, bed counts, and number of discharges.

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: During the assessment process, the program provided baselines and adopted targets for its new annual output measures.

Evidence: The baseline for all payments processed on time was 100% in FY2002. The target for FY2003-FY2006 is 100% of all payments made on time.The baseline percentage of hospitals whose FTE resident counts were verified in FY2003 is 100%. The targets are 100% for FY2004 and beyond. The baseline percentage of hospitals whose FTE caps were verified in FY2003 is 100%. The targets are to verify 100% in FY2004 and beyond.The baseline percentage of hospitals whose case-mix index, bed counts, and number of discharges were verified in FY2003 is 0%. The targets are to: 1) Develop methodologies for verifying case-mix indices, bed counts, and discharges, and estimate costs of verification in FY2005; 2) Pilot test the methodologies and determine feasibility/cost effectiveness in FY2006; and 3) Contingent upon the results of pilot studies, develop a Federal Register to solicit comments on any proposed changes in FY2007; 4) Contingent upon the results of pilot studies and comments received in response to the Federal Register notice, implement additional verification procedures for all hospitals case-mix indices, bed counts, and number of discharges in FY2008.

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: The program has expressed commitment to work towards the long-term and annual goals. The program's long-term and annual goals call for the program to seek input from program partners in determining the feasibility and cost effectiveness of verifying case-mix indices, bed counts, and discharges.

Evidence: Questions 2.1, 2.2, 2.3, and 2.4.

Program Assessment Rating Tool (PART)

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: NO Question Weight: 12%

Explanation: Children's Hospital Graduate Medical Education Program does not have regularly scheduled objective, independent evaluations that examine how well the program is meeting its long-term goals and recommend how to improve the program's performance.

Evidence: Moody's, a bond rating firm, publishes regular bond rating reports on children's hospitals. However, these bond reports are designed to evaluate the credit characteristics of children's hospitals. They comment favorably on CHGME, but do not evaluate the program or examine how well the program is accomplishing its purpose.

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: The program allocation formula is specified by Congress in the authorizing legislation and annual requests appropriations are not based on a determination of resources needed to meet specific quantifiable goals.

Evidence: Section 340E of the Public Health Service Act, HRSA Congressional Justification

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: The Bureau of Health Professions (BHPr), the Bureau within HRSA that oversees CHGME PP, revised its strategic plan to address planning deficiencies noted during FY2004 PART reviews. The Bureau is also systematically reviewing all of its programs, including CHGME PP, using a logic model approach to articulate program missions, develop meaningful and measurable outcomes, and improve coordination among programs. The Bureau also plans to improve their data system to meet the data requirements of the new performance measures and publish standardized reports on BHPr programs on HRSA website. This process is in the early stages of implementation and is expected to take about two years.

Evidence: Strategic plan, performance measurement workgroup meetings, and program logic models.

Program Assessment Rating Tool (PART)

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 11%

Explanation: CHGME PP receives regular feedback from CMS, eligible children's hospitals, fiscal intermediaries, and the trade association on how to manage the program and improve performance.

Evidence: During the first cycle of the CHGME PP applications, freestanding children's hospitals were not sufficiently versed in the laws and regulations governing GME payments. In response, the program created a comprehensive Technical Assistance Program designed to teach representatives of these hospitals how to complete the CHGME PP applications and error rates were reduced. Eligible children's hospitals did not know how to establish an Medicare GME affiliation agreement with other hospitals. CHGME PP invited CMS policy analysts to provide a detailed explanation to eligible hospitals on how to establish affiliation agreements. On a Technical Assistance Conference call in October 2002, about 80 participants participated in a tutorial on affiliation agreements. After the conference call, the number of queries regarding affiliation agreements decreased significantly. The program also contracted with Medicare FIs to make CHGME FTE assessments a higher priority to allow hospitals to finalize their FTE resident counts within the CHGME PP time frame.

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 11%

Explanation: The agency's senior management is held responsible for the operations of their programs, including performance results. HRSA reports that all of its SES personnel have performance contracts with goals, states and outcomes that are results oriented. In addition, there are four Federal Regional Managers who each take responsibility for approximately fifteen CHGME hospitals. The role of these managers is to ensure that the hospital understands and successfully complies with the law and the timelines of the CHGME PP. The hospitals are held accountable under federal law for reporting their data correctly.

Evidence: Each supervisor is rated yearly on their Performance Evaluation Plan (PEP) that includes rating for: (1) individual work management, (2) technical competency, (3) innovation, and (4) customer service.All information filed by the hospitals is subject to audit by the Department and the General Accounting Office. No audits have been conducted to date. However, the program has adopted goals to ensure the accuracy of hospital data.

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 11%

Explanation: To date, all CHGME PP funds have been obligated and disbursed in a timely manner. By statute, payments are made on a bi-weekly basis and the program withholds 25 percent of the funds until the final determination of each hospital's payment amount is made in the spring of each year. All CHGME PP payments are disbursed by the end of each FY. In order to receive their proportionate share of CHGME PP funds, children's teaching hospitals complete an initial and a reconciliation application. CHGME PP has no oversight over how the hospitals utilize the funds.

Evidence: Section 340E of the Public Health Service Act outlines the formula, but does not give CHGME authority to oversee how the hospitals use the funds. On March 1, 2001, CHGME PP published a Federal Register notice detailing eligibility and payment methodology. On July 20, 2001, HRSA published an additional Federal Register notice detailing the methodology for determining FTE counts and the calculation of Indirect Medical Education (IME) payments. At the end of each fiscal year, the CHGME PP publishes a press release listing the total amount received by each of the children's teaching hospitals that applied for and received program funds.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: YES Question Weight: 11%

Explanation: The CHGME PP has efficiency targets related to: 1) processing applications; 2) estimating payments; and 3) distributing payments. To date, the CHGME PP has been able to make payment calculations and process award letters and vouchers within one week of receiving a budget for disbursement. The program has contracted with fiscal intermediaries (FIs) to perform reviews of FTE resident counts for those hospitals that file full Medicare Cost Reports, as well as for those that file low or no utilization Medicare Cost Reports (MCRs). The FIs submit an assessment of FTE resident counts for each reconciliation application to ensure that the hospitals counts were made in accordance with program rules and regulations.

Evidence: In FY 2001, the CHGME PP developed streamlined application materials and obtained OMB approval to implement them FY 2002. Major improvements included simplification of the application form and enhancement of the guidance material to include an explanation of the legislative requirements, along with identification of references and sources that allow applicants to gain a deeper understanding of the issues.The CHGME PP application and associated guidance are available electronically on the CHGME PP web site. Because of the need for certification and assurances by the hospitals, the program also requires a hard copy with original signatures.The financial database used to calculate payments has been improved to facilitate the reallocation of funds overpaid prior to reconciliation, based on the final determination of FTE resident counts. An expanded program of technical assistance has reduced confusion related to Medicare GME rules, and decreased the number and types of errors that hospitals make on their applications.

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 11%

Explanation: Since CHGME PP is based in large part on Medicare rules and policies, CHGME PP has implemented several procedures to avoid overlap with CMS procedures, including verification of a children's hospital's FTE resident count. CHGME PP is currently working with CMS on the development of an alternative case-mix index for children. The trade association, the National Association of Children's Hospitals (NACH), computes the case-mix index for two thirds of the eligible hospitals. The program obtains aggregate data from NACH.

Evidence: HCFA Transmittal A-01-75HCFA Transmittal AB-02-007

Program Assessment Rating Tool (PART)

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

3.6 Does the program use strong financial management practices? Answer: NO Question Weight: 11%

Explanation: The September 30, 2002 and 2001 independent auditor's report for HRSA identifies five reportable conditions. 1) Preparation and analysis of financial statements - HRSA's process for preparing financial statements is manually intensive and consumes resources that could be spent on analysis and research of unusual accounting. 2) Health Education Assistance Loan (HEAL) program allowance for uncollectible accounts HRSA's financial statements indicate limited success in collecting delinquent HEAL loans. 3) Federal Tort Claims Liability HRSA is unable to estimate its malpractice liability under the Health Centers program. 4) Accounting for interagency grant funding agreements HRSA's interagency grant funding agreement transactions are recorded manually and are inconsistent with other agencies procedures. 5) Electronic data processing controls HRSA has not developed a disaster recovery and security plan for its data centers. Although HRSA's CHGME PP have not been cited specifically by auditors for material weaknesses, the above reportable conditions constitute weaknesses within HRSA and its Office of Financial Integrity. The Office reports directly to the Administrator and is intended to ensure procedures are in place to provide oversight of all of HRSA's financial resources.

Evidence: The audit assessment is based on the independent auditor's reports for 2001-2002.

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 11%

Explanation: HRSA developed a corrective action plan to address the reportable conditions identified in the September 30, 2002 and 2001 independent auditor's report. For each aspect of the five reportable conditions, HRSA assigned an office responsibility. The plan also outlines milestones and target completion dates.During the PART process, HRSA adopted goals to explore the feasibility of verifying the case-mix indexes, discharges, and number of inpatients days reported by each hospital.

Evidence: Questions 2.1, 2.2, 2.3, 2.4HRSA Corrective Action Plan for FY2002 Financial Statement Audits as of 4/30/2003.

3.BF1 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: NO Question Weight: 11%

Explanation: By law, the program is required to make a final determination of FTE residents counts. CHGME PP fiscal intermediaries verify the FTE counts and caps for each hospital. However, the program does not verify the case-mix indexes, discharges, and number of inpatients days used in the IME payment calculation. The program has adopted goals to explore the feasibility of verifying this hospital-reported data.

Evidence: Public Health Service Act Section 340EQuestion 2.1, 2.2, 2.3, and 2.4

3.BF2 Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner? Answer: NO Question Weight: 11%

Explanation: The program does not provide hospital-specific data in an accessible format. The GPRA report provides aggregated data on the number of FTE residents trained in eligible hospitals, but does not provide hospital specific data. The program does not make publicly available aggregated or hospital specific data on bed counts, case-mix indexes, and discharges. The GPRA report also provides aggregate data on the proportion of all eligible hospital's gross revenue from patient care attributed to public insurance and uninsured patients and the percentage of hospitals funded by the program with negative total margins. The program publishes aggregate and hospital-specific funding levels. At the end of each fiscal year, the program publishes a press release detailing the total payment for each hospital.

Evidence: FY2004 GPRA PlanFY2002 HSRA press release on annual payments to eligible hospitals

Program Assessment Rating Tool (PART)

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

4.1 Has the program demonstrated adequate progress in achieving its long-term performance goals? Answer: SMALL EXTENT Question Weight: 25%

Explanation: The program has taken action to verify the hospital's FTE counts including comparing data with Medicare FIs and pervious years data. In addition, the program commissioned with Blue Cross Blue Shield Association to assess the FTE resident caps and the weighted and unweighted FTE resident counts.The program has adopted a new long-term measure to verify all hospitals bed counts, case-mix indices, and number of discharges contingent on the results of pilot studies. However, no actions have been taken to date to assess the feasibility and cost-effectiveness of additional verification for bed counts, case-mix indexes, and discharges in each hospital.

Evidence: The baseline year for these goals is 2003 and progress towards one of the goals has been started. The target year for verification of FTE caps and counts is FY2003. The target year for verification of case-mix indices, bed counts, and discharges, contingent upon the results of pilot studies comments received in response to the Federal Register notice, is FY2008.

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: LARGE EXTENT Question Weight: 25%

Explanation: The program currently meets its goal of processing payments on time and 100% of hospitals FTE residents caps and counts will be verified in FY2003. However, no actions have been taken to assess the feasibility and cost-effectiveness of additional verification for bed counts, case-mix indexes, and discharges in each hospital.

Evidence: Questions 2.1, 2.2, 2.3, and 2.4.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: YES Question Weight: 25%

Explanation: The program met the standards for a Yes in Question 4 of Section III due to steps taken to improve the efficiency. The program has implemented several technological improvements including placing the application on the web and documenting email correspondence with hospitals. There is no evidence of improved efficiency per Federal dollar at the actual program level, since any savings in administrative costs are transferred to the eligible children's hospitals or held until the next fiscal year.

Evidence: Question 3.4

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: NA Question Weight: 0%

Explanation: Medicare and Medicaid Graduate Medical Education payments, Health Professions, and National Health Service Corps (NHSC) also support hospitals and other institutions that train health professionals. However, a unit cost comparison between these programs is inherently difficult due to the relative size of the programs and different outcome measures.

Evidence: NHSC tracks the number of patients served by the placement and retention of a NHSC clinician and the average Health Professional Shortage Area (HPSA) score of areas receiving a NHSC clinician. Health Professions tracks the proportion of persons who have a specific reliable source of continuing health care, the proportion of grantees completing funding program that are serving in medically underserved communities, and the proportion of grant recipients of an underrepresented minority or disadvantaged background. Medicare and Medicaid GME reimburse hospitals for services used by their beneficiaries.

Program Assessment Rating Tool (PART)

Program: Children's Hospitals Graduate Medical Education Payment Program
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	67%	50%	

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?**

Answer: NO Question Weight: 25%

Explanation: No comprehensive independent evaluations of CHGME PP have been conducted.

Evidence: Question 2.6

Program ID: 10001063

PART Performance Measurements

Program: Children's Hospitals Graduate Medical Education Payment Program

Agency: Department of Health and Human Services

Bureau: Health Resources and Services Administration

Measure: Percent of hospitals with verified bed counts, case-mix index, and number of discharges. This measure is contingent upon the results of pilot studies to be completed in FY2006.

Additional Information:

Year	Target	Actual	**Measure Term:** Long-term
2008	100%		

Measure: Percent of hospitals with verified FTE resident counts and caps

Additional Information:

Year	Target	Actual	**Measure Term:** Long-term
2003	100%		
2004	100%		
2005	100%		
2006	100%		
2007	100%		

Measure: Percent of payments made on time

Additional Information: The percentage of payments to hospitals made every 2 weeks. Monthly payments are made early in each fiscal year while final program allocations are determined.

Year	Target	Actual	**Measure Term:** Annual
2002	100%	100%	
2003	100%		
2004	100%		
2005	100%		
2006	100%		

PART Performance Measurements

Program: Children's Hospitals Graduate Medical Education Payment Program

Agency: Department of Health and Human Services

Bureau: Health Resources and Services Administration

Measure: Percent of hospitals with verified FTE resident counts and caps

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2003	100%		
2004	100%		
2005	100%		
2006	100%		
2007	100%		

Measure: Actions to assess the feasibility and cost effectiveness of verifying hospitals bed counts, case-mix indices, and number of discharges.

Additional Information: See 2.4 for detailed information on targets.

Year	Target	Actual	**Measure Term:** Annual
2005	Develop Methods		
2006	Pilot test		
2007	Fed Reg notice		
2008	Verifiy data		

OMB Program Assessment Rating Tool (PART)

Competitive Grant Programs

Name of Program: Children's Mental Health Services

Section I: Program Purpose & Design (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The program purpose is to make grants to public entities to support comprehensive community mental health services to children with a serious emotional disturbance. The legislation specifies competitive grants will be used to establish systems of care for children with a serious emotional disturbance that provide specific minimum mental health services. The legislation also clearly outlines the term and matching requirements of the grants. The purpose is commonly shared by interested parties.	Comprehensive Community Mental Health Services for Children and Their Families was authorized in 1992 (section 561 to 565 of the Public Health Service Act). Agency and Congressional reports related to the program are consistent with the program purpose as outlined in the authorizing legislation. The program is run by the Substance Abuse and Mental Health Services Administration (SAMHSA).	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The program is designed to support and improve mental health services in the community for children with serious emotional disturbance. The agency defines the target population as "children and youth with a serious emotional disturbance from birth to age 21 who currently have, or at any time during the past year had, a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM–IV), that resulted in functional impairment that substantially interferes with or limits one or more major life activities."	An estimated 4.5 to 6.3 million children in the United States have a serious emotional disturbance. The 1999 Report of the Surgeon General on mental health found children with serious emotional disturbance are best served with a systems approach; and 75-80% of children with serious emotional disturbance are not receiving specialty mental health services. Prior to managed care, some state community mental health centers offered no children's mental health services. There are no data on the number of communities that have implemented a system of care approach.	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	No	The program is reaching a relatively limited number of individual communities and the national impact in the context of all other factors is not fully known. With an emphasis on changing the mental health system and a required graduated match from grantees, the program is designed to have a significant and lasting impact in individually funded communities. The program provides incentives for systems reform and provides seed money for developing new community-based mental health services and enhancing existing services. The program also includes a national public information and education campaign to increase public awareness that began in 1994, though the impact of this campaign is unknown.	The program provides grants to local entities and from its inception has reached 8% of the nation's counties. The program has funded individual grantees in 43 states. Some state governments have adapted the program's approach to additional communities within the state, but in general the impact of the Federal investment is confined to those communities receiving funds. The program has leveraged an estimated $200 million from state, local and private sources, nearly one third of the Federal contribution. The program estimates at current levels it would take 16 years to reach one quarter of the nation's communities.	20%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	Children's Mental Health is the only Federal funding source targeted to support comprehensive, community-based mental health services for children with serious emotional disturbance. There is little evidence of widespread state or local investment in establishing systems of care.	The Robert Wood Johnson Foundation supported a program with similar goals in the 1980s that served as a foundation for Children's Mental Health. The Foundation also supported a replication program in 1993.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The program is administered through cooperative agreements with communities and provides direct contact to influence system changes at the community level.	There is no evidence that providing support through a block grant or other mechanism would be more effective or efficient than competitive awards direct to communities.	20%	0.2
Total Section Score					**100%**	**80%**

Section II: Strategic Planning (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	The program has adopted long-term outcome goals focused on measuring performance and sustainability of funded communities. Program grants are designed to enable a community to establish a systems of care approach to children with serious emotional disturbance and support mental health services. Clinical improvement in child behavior after treatment is a key measure of program impact. Sustainability of systems of care after the end of the grant cycle provides information on the effectiveness of the community by community approach. An additional goal on program cost is under review to provide evidence of program efficiency beyond the sustainability of new systems of care.	The long-term outcome measures will track the clinical impact of funded sites on children receiving services as measured by scores on a standardized child behavior checklist. The program provides support to transform a mental health system, which relies on the participation of juvenile justice, education and other service sectors. The legislation requires matching funds in order to broaden the reach of the program and increase the likelihood that the new system will be maintained after the conclusion of the six year grant cycle. A second measure adopted by the program will track the percent of systems of care that are sustained five years after program funding has ended.	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	The program has a limited number of annual performance goals that are quantifiable and relevant to the mission. The annual goals relate directly to the long-term outcomes and purposes of the program. The goals address both individual outcomes for children receiving services and the performance of systems of care within funded communities.	Children's Mental Health annual goals include: 1. Decrease average days in inpatient or residential facilities; 2. Increase percentage of referrals from juvenile justice system to system of care; 3. Sustain at least 80% of systems of care five years after they have stopped receiving Federal funds through the program.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	The program's direct grantees provide performance data on the program's annual goals to the agency. Each award recipient is required to report performance on a quarterly basis to an evaluation contractor. The evaluation contractor conducts a cross-site national evaluation. The agency also works with award recipients to use performance data for their own strategic planning.	Award recipients dedicate two FTE for the evaluation system. Performance data are entered directly into a computer and are reported to the national evaluation contractor quarterly through a web-based system. These data are compiled and reported in the program's annual report.	14%	0.1
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	The program collaborates and coordinates at both the grantee level and the Federal level. At the local level, collaboration between education, juvenile justice, and the mental health system is central to the program goal to integrate services at the local level. Federal level collaboration takes the form of meetings, funding for technical assistance, and reimbursable agreements.	At the grantee level, projects are required to develop collaborative relationships across child-serving sectors in the community including education, child welfare, juvenile justice, and mental health. At the Federal level, the program collaborates with the National Institute of Mental Health, the Health Resources and Services Administration, the Administration on Children and Families and the Department of Education.	14%	0.1
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	As required by the authorizing legislation, the program supports an annual evaluation to demonstrate the effectiveness of the systems of care approach supported by the program. The evaluation is focused on program goals and is conducted through a private contractor external to the program and funded sites. Outcome data are collected from each funded site beginning in the third year of the six year grant period. The evaluation measures the effectiveness of the program and presents recommendations for program improvements. The program produces an annual report to Congress on evaluation results. The latest report focuses on 31 grant communities that established systems of care for approximately 40,029 children and their families.	Each site is visited three times during each six year award cycle. Evaluated elements include the extent to which systems of care develop and improve over time, type and amount of services children receive, cost of services, improvements in clinical and functional outcomes and family life, duration of improvements, attribution to systems of care approach, and relative effectiveness of the intervention. The evaluation consists of a study of the demographic and functional characteristics of children and families at intake, child and family outcome study, a measures of the incorporation of the systems of care approach into service at the clinical and systems levels, and a study of the cost-effectiveness of the program.	14%	0.1
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	Annual budget requests are not clearly derived by estimating what is needed to accomplish long-term outcomes. The program has different output goals and has not identified how much cost is attributed to each goal. The program is able to estimate outputs (number of communities funded and children served) per increased increment of dollars. Program management funds are budgeted separately.	This assessment is based on the annual budget submission to OMB and the Congress.	14%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	The deficiency highlighted in this section relates to program budget alignment with program goals. Through this process, the program has adopted new long-term goals that capture intended outcomes of the program. The program is estimating the likely outcomes of the program based on past performance. Having these measures in place will further enable the program to integrate budget planning and strategic planning and determine the level of financial resources needed to obtain long-term outcomes.	The program has adopted new long-term goals. The agency also reports developing performance based budgeting to strengthen the links between performance and budget. The agency's restructuring plan consolidated budget formulation, planning and Government Performance and Results Act activities within one unit.	14%	0.1
Total Section Score					**100%**	**86%**

Section III: Program Management (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	The program collects performance information on an annual basis and uses the information to manage the program and improve performance. Cross-site data have been collected since 1995 when the program's national evaluation was first implemented.	For example, when data showed a decrease in referrals from child welfare and education systems in FY 2001, the program increased technical assistance to grantees to emphasize interagency collaboration at the local level through expertise in child welfare, education, juvenile justice and primary care.	9%	0.1
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	No	Federal managers are not held accountable for results through employee evaluations or other mechanisms. The program manager is responsible for ensuring that Project Officers exercise adequate surveillance and quality control over the activities of grantees and contractors. The agency does use annual performance data to hold funded communities accountable for their results. The program also uses performance contracts to monitor the performance of its evaluation and technical assistance contractors.	The assessment is based on discussions with the agency and program manager vacancy announcements. Employee evaluations at the agency are handled by each of the agency's three centers.	9%	0.0
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	The program obligates funds on schedule and monitors use for the intended purpose. Award recipients typically spend awards during the single fiscal year. Federal managers review expenditures for contracts on a monthly basis and approve or disapprove reimbursement items.	The assessment is based on apportionments, program evaluation forms and financial status reports. The agency is also working on establishing waves of grant announcements to improve the distribution of obligations through the fiscal year.	9%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	The program can take additional steps to improve administrative efficiency, but does have some incentives and procedures in place. The program operates with a relatively limited number of Federal staff. The agency relies on an HHS service clearinghouse known as the Program Support Center for many internal services. The agency is providing FAIR Act targets and appears to be making progress toward outsourcing additional services. Outsourced activities include accounting, graphics, human resources, and property management. The program contracts out evaluation, technical assistance, public education, and logistics. Performance data are collected electronically and reported through a web-based system known as the Interactive Collaborative Network. Federal staff also review proposed budgets to identify excessive or inappropriate costs.	The assessment is based on discussions with the agency, FAIR Act reports, and the description of services directed to HHS' consolidated Program Support Center.	9%	0.1
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program is unable to cost out resources needed to achieve targets and results. The program does not capture all direct and indirect costs borne by the program agency, including applicable agency overhead, retirement, and other costs budgeted elsewhere, or include informational displays in the budget that present the full cost of outputs. FTE and administrative expenses are not tied to annual program budgets. The program does not have a financial management system that fully allocates program costs and associates those costs with specific performance measures. The program does develop annual budget proposals that include associated FTE costs.	The assessment is based on annual program management budget requests to OMB and Congress.	9%	0.0
6	*Does the program use strong financial management practices?*	Yes	IG audits of the agency's financial management have identified no material internal control weaknesses. The agency's fiscal monitoring of grant awards is conducted through the SAMHSA Grants Information Management System (SGIMS), which tracks awards and obligations, carry over and submission of quarterly reports, application renewals and final reports.	The assessment is based on conversations with the agency, audited statements and Office of the Inspector General reports.	9%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	The main deficiencies include use of performance data to enhance accountability and the ability to identify changes in performance with changes in funding levels. Most significantly, the agency reports taking additional steps to hold staff accountable for program performance.	The agency has begun rolling out performance contracts as part of an overall management reform plan that will set specific, quantitative targets. These contracts are to include outcome elements focused on program goals. The agency's restructuring plan consolidated budget formulation, planning and Government Performance and Results Act activities within one unit.	9%	0.1

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
8 (Co 1.) *Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?*	Yes	A central office within the agency organizes and conducts independent review of grant applications for agency programs. Applications for this program are peer reviewed based on clear criteria and awards are made based on merit as judged through the peer review process.	Assessment based on grant review procedures, Federal Register Notices. Congress does not include earmarks for this program.	9%	0.1
9 (Co 2.) *Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	Yes	The program encourages participation of public entities that have never been funded before. The program is designed to establish sustainable changes in funded communities that will not require Federal funding once the six year grant period has ended. The program also funds grantees in new geographic regions of the country. The program also provides technical assistance to prospective applicants and those that have applied but not received an award.	Since its inception, the program has funded 67 grants in 43 states and eight Native American Tribes. The FY 2002 grant announcement introduced set-asides for territories and cities of 500,000 or more to encourage grant applications from areas which have not received funding.	9%	0.1
10 (Co 3.) *Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	Federal staff serving as project officers receive data on grantee activity quarterly through the agency's SGIMS system. Project officers visit each funded site accompanied by agency consultants in years two and four of the grant cycle and as needed. The national evaluation contractor also conducts site visits three times during the grant period. Project officers review and approve annual budgets and monitor non-federal match funding. Grantees report annually on performance.	The assessment is based on copies of grantee reports, and site visit protocol documents.	9%	0.1
11 (Co 4.) *Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	Data are collected and compiled through the national evaluation of the program conducted since 1995. Annual performance data are summarized in the performance report and made available on the agency web site. Additional steps could be taken to make performance data by state or community available to the public.	Assessment based on agency GPRA reports and web site (www.samhsa.gov). Additional data outside of GPRA are reported through the agency's mental health web site (www.mentalhealth.org) and through annual reports to Congress on the program, which are also available on the agency web site. On a more ad hoc basis, performance data are conveyed through journal articles and at professional and grantee conferences and meetings.	9%	0.1
Total Section Score				**100%**	**82%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section IV: Program Results (Yes, Large Extent, Small Extent, No)						
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Small Extent	The program has adopted new long-term outcome goals that are ambitious and relate to the mission of the program. The measure of clinical effectiveness is based on the number of communities that exceed a 30 percent improvement in behavioral and emotional symptoms among children receiving services for six months. Program impact is also measured by the percentage of funded communities maintaining systems of care five years after no longer receiving Federal support. Currently, the oldest cohort of grantees is only three years out from receiving Federal support and 80% of these communities have maintained a system of care approach to children's mental health. An additional goal is under consideration to measure program efficiency, such as a measure of average cost of treatment before and after implementing a system of care approach. A possible third measure is under review as a means of capturing the reduction of more costly treatment modalities realized from a system of care approach. These data are already tracked for the annual measure.	The improvement in behavioral and emotional symptoms is derived from a calculation of the Reliable Change Index (RCI, Jacobson & Truax, 1991) for the intake and six month scores of the Child Behavior Checklist (CBCL), a standardized measure of behavioral and emotional symptoms (Achenbach, 1991).	25%	0.1

Long-Term Goal I:	Increase the percent of funded sites that will exceed a 30 percent improvement in behavioral and emotional symptoms among children receiving services for six months. (new measure)
Target:	50% by 2010
Actual Progress achieved toward goal:	30% in 2001; 43% in 2000
Long-Term Goal II:	Increase the percent of systems of care that are sustained five years after Federal program funding has ended. (new measure)
Target:	FY 2008: 80% of grants 5 years out from end of funding.
Actual Progress achieved toward goal:	In FY 2001, 86% of the seven sites were sustained 3 years after end of funding; in FY 2000 100% of four sites were sustained.
Long-Term Goal III:	Decrease in average costs of use of inpatient or residential facilities among children served in systems of care. (draft measure)
Target:	To be established March 1
Actual Progress achieved toward goal:	To be established March 1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program (including program partners) achieve its annual performance goals?*	Large Extent	The program sets annual targets and is meeting those targets. The annual goals provide information on program progress toward meeting its long-term outcomes. One measure related to system efficiency is the average number of inpatient or residential days. This measure captures both improvements in system approaches and also provides a rough indication of potential reductions in overall costs to the system associated with more expensive mental health care services. This measure was not adopted as a long-term outcome because only 5% of children served by the program enter the system from a residential care treatment facility, and the measure is insufficiently representative of the program's total long-term outcomes. The annual measure will also track system sustainability after the conclusion of Federal funding.	Data on program outcomes are collected from a multi-site outcome study that uses self-reported delinquency surveys. Reductions in inpatient treatment are tracked by comparing data from grantees with a restrictiveness of living environments scale. Sustainability data have been collected by contract using a checklist of key system components.	25%	0.2

Key Goal I:	Decrease average days of inpatient/residential treatment among children with serious emotional disturbance in grantee communities over the past year.
Performance Target:	FY 2001: 159 days
Actual Performance:	FY 2001: 152 days (43% decrease from the FY 1997 baseline of 265 days)
Key Goal II:	Increase percentage of referrals from juvenile justice system to system of care.
Performance Target:	FY 2001: 14.4%
Actual Performance:	FY 2001: 15.1% (68% increase from the FY 1997 baseline of 9%)
Key Goal III:	Sustain at least 80% of systems of care five years after they have stopped receiving Federal funds through the program.
Performance Target:	FY 2004, 80% sustained 5 years after end of funding.
Actual Performance:	In FY 2001, 86% of the seven sites were sustained 3 years after end of funding; in FY 2000 100% of four sites were sustained.

3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Small Extent	The agency is meeting the standards of a Yes for having incentives and procedures to measure and achieve efficiencies and has realized some improved efficiencies at the Federal program level. The agency is taking further steps to improve efficiency through reductions in deputy manager positions and consolidation of smaller offices. The average number of children served in the second year of the grant shows some upward movement from the 1997 to 1999 grantee cohorts. However, the average number of days in residential treatment has crept upward from 1998 to 2001. A Large Extent or Yes would require additional data on improvements in efficiencies and cost effectiveness in achieving program goals in the last year.	Assessment is based on annual performance reports, agency restructuring plans, and discussions with agency managers. The average number of children receiving services in the first operational year increased from 23 to 36 between 1998 and 1999 and in the second operational year from 105 to 179. The average number of days in residential treatment is below the 1997 baseline, but increased from 143 in FY 1998 to 152 in FY 2001. Improved efficiency data are needed.	25%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	NA	As noted in Section I, Children's Mental Health is the only Federal funding source targeted to support comprehensive, community-based mental health services for children with serious emotional disturbance.	The performance of this program is similar to a Robert Wood Johnson Foundation Demonstration program and a predecessor program at the National Institute of Mental Health, but not to any existing Federal programs.	0%	
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Yes	The results of the program's annual evaluation indicate the program is effective and achieving results. Data are reported in GPRA, but the most comprehensive reporting of program performance is found in annual reports to Congress. The 1999 report presents data accumulated through August 1999 from 22 grant communities initially funded in either FY 1993 or FY 1994 and 9 grant communities first funded in FY 1997. The evaluations have found that children are able to function better in school, at home and in society than when they first started in the program. After two years of services, 42 percent of the children showed a significant reduction in severe behavioral and emotional problem symptoms and an additional 48 percent of the children were stabilized. The children have fewer behavioral and emotional problems, their behavioral and emotional strengths improve, and their level of impairment decreases. Effected families as a whole are functioning better than when they first started to participate in systems of care programs.	Selected findings in the most recent report include: regular school attendance increased from 85.9 percent at entry into services to 89.4 percent after 1 year; the percentage of children who had scores below 40 on the Child and Adolescent Functional Assessment Scale more than doubled, from 13.5 percent to 29 percent, indicating these children are no longer clinically impaired in their social functioning; and law enforcement contacts were reduced by 25 percent among children who remained in services after 1 year.	25%	0.3
Total Section Score					**100%**	**58%**

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Breast and Cervical Cancer
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	64%	25%	

1.1 Is the program purpose clear? Answer: Yes Question Weight: 20%

Explanation: CDC's breast and cervical cancer program was established by P.L. 101-354 (Public Health Service Act, Title XV). The law states that the purpose is to screen low-income women and to provide public education, quality assurance, surveillance, partnerships and evaluation regarding breast cancer screening among low-income women.

Evidence: Public Health Service Act Title XV.

1.2 Does the program address a specific interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: In 2002, an estimated 203,500 new cases of breast cancer will be diagnosed and 39,600 of those women will die from the disease. Breast cancer accounts for more than one third of all cancers in women. While the incidence of cervical cancer is on the decline, in 2002, an estimated 13,000 new cervical cancer cases will be diagnosed, and 4,100 women will die. CDC targets low-income, uninsured or underinsured women who do not have insurance coverage for screenings, who tend to have higher cancer mortality rates and lower survival rates. Without this program, this population of women would not be screened.

Evidence: 1. All deaths from cervical cancer and more than 30% of deaths from breast cancer among women 50 years and older could be prevented through the widespread use of screening mammography and Pap tests. 2. Research indicates that precancerous conditions and invasive cervical cancer are more likely to be found in women who have never been screened or not screened within the last five years. 3. This program provides screening services for low-income women (up to 250% of poverty) ages 50-64 who do not qualify for other health insurance programs such as Medicare, Medicaid or private insurance. CDC estimates it reaches about 15% of its eligible population with screening services.

1.3 Is the program designed to have a significant impact in addressing the interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: CDC provides the only access to screening services for this population. The CDC program leverages state funds and requires a $1 match (can be through in-kind contributions) for every $3 Federal dollars provided.

Evidence: As of March 2001, the NBCCEDP has provided more than 3 million screening tests to over 1.3 million women, and there have been 10, 649 cases of breast cancer, 43,154 pre-cancerous cervical lesions, and over 700 cases of invasive cervical cancer diagnosed.

1.4 Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)? Answer: Yes Question Weight: 20%

Explanation: This program fills a gap for those women who do not have insurance coverage for these screening services and serves as the payer of last resort for these services.

Evidence: This is the only Federally-funded program to provide this population of women with access to screening services and public education. This program targets those women who may be the hardest to reach for screening services.

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Breast and Cervical Cancer
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	64%	25%	

1.5 Is the program optimally designed to address the interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: CDC distributes its funding through cooperative agreements, providing states with some flexibility, but requiring that states meet certain programmatic requirements.

Evidence:

2.1 Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program? Answer: No Question Weight: 14%

Explanation: The long-term targets that have been developed are not ambitious, nor are they outcome goals. Two of the program's previous goals related to early detection of breast cancer and preventing cervical cancer through screening were closer to outcome goals, but have now been excluded from the GPRA plan due to data problems. An efficiency measure capturing the reach of the federal investment should also be considered, including perhaps measure of screens per federal dollar. The program has developed several long-term targets for its two primary goals: 1) expanding community-based breast and cervical cancer screening and diagnostic services to low-income, medically underserved women; 2) For women diagnosed with cancer or pre-cancerous conditions, assure access to treatment services. Increasing the number of women screened is a direct input based on level of resources, so this is not considered an adequate long-term goal.

Evidence: The long-term goals for FY 2008 include: 1) Increase the number of women screened for breast and cervical cancer from 255,000 in FY 2004 to 310,000; 2) Increase the percentage of newly enrolled women who have not received a Pap test within the past five years from 22.5% in FY 2004 to 26%; 3) Increase the percentage of women with abnormal results who receive a final diagnoses within 60 days of screening from 85% to 92% for breast cancer and 63% to 64% for cervical cancer; 4) increase the percentage of women with cancer who start treatment within 60 days for diagnosis from 95 to 96% for breast cancer and from 90 to 92% for cervical cancer, and 5) increase the percentage of women with pre-cancerous lesions who start treatment within 90 days of diagnosis from 93.5 to 94%.

2.2 Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals? Answer: Yes Question Weight: 14%

Explanation: CDC has developed a new set of annual GPRA performance goals to help measure progress on these long-term goals that focus on: 1) screening and rescreening additional women; 2) reaching hard-to-reach women who are more likely to have cancer; and 3) quality assurance for its programs and making sure women screened through their program are linked to appropriate treatment services in a timely manner.

Evidence: New measures for FY 2004 include: 1) increase the percentage of newly enrolled women who have not received a Pap test within the past five years from 21.7 to 22.5%; 2) increase the percentage of women with abnormal results who receive a final diagnosis within 60 days of screening from 82 to 85% for breast cancer and from 61 to 63% for cervical cancer; 3) increase the percentage of women with cancer who start treatment within 60 days of diagnosis - from 94 to 95% for breast cancer; from 88% to 90% for cervical cancer; 4) increase the percentage of women with precancerous lesions who start treatment within 90 days of diagnosis from 92 to 93.5%.

Program:	Chronic Disease - Breast and Cervical Cancer
Agency:	Department of Health and Human Services
Bureau:	Centers for Disease Control and Prevention
Type(s):	Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	64%	25%	

2.3 **Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?** Answer: Yes Question Weight: 14%

Explanation: CDC requires all of its grantees to develop goals and quantitative objectives, indicating how the grantee will help CDC meet its stated goal of assuring screening services for low-income women, and also to measure grantee's progress in meeting its stated goals/objectives.

Evidence: The guidance for the grantees indicates that each state must implement a breast and cervical cancer early detection program that meets or exceeds expectations in each of the NBCCEDP components.

2.4 **Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?** Answer: Yes Question Weight: 14%

Explanation: CDC works with a variety of Federal programs that provide similar screening services to its respective populations.

Evidence: CDC works with HRSA's Bureau of Primary Health Care's community and migrant health centers to screen their population and provide appropriate follow-up. CDC deploys staff to IHS to serve as technical advisors for its programs.

2.5 **Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?** Answer: Yes Question Weight: 14%

Explanation: Several independent evaluations have been conducted on specific activities related to the breast and cervical cancer program (e.g., adequacy of minimum data elements, rescreening rates, treatment services), as there is fairly strong evidence that screening and rescreening women can help reduce mortality rates for breast and cervical cancer. While none of these evaluations are comprehensive studies of the breast and cervical cancer program's effectiveness, the program is planning a comprehensive five-year program evaluation (Research Triangle Institute) and will have the plans for this evaluation by this Fall.

Evidence: Completed independent evaluations: 1) Assuring quality of Minimum Data Elements (MDE) (Batelle); 2) Follow-Up and Treatment Issues in the Program (Batelle); 3) Mammography Rescreening Rates (Batelle).

2.6 **Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?** Answer: Yes Question Weight: 14%

Explanation: Since most of the program dollars are spent on screening services and 60% of grantee funds have to be spent on clinical services, there is a strong link between the levels of funding and services provided. CDC can set screening targets based on the level of resources provided. CDC's budget structure, financial accounting structure and GPRA plan are aligned.

Evidence: For example, in the FY 2003 Budget, with an additional $9 million, the program estimated it could provide an additional 29, 000 screenings.

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Breast and Cervical Cancer
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	64%	25%	

2.7 Has the program taken meaningful steps to address its strategic planning deficiencies? Answer: Yes Question Weight: 14%

Explanation: CDC has committed to developing new long-term performance measures that are focused on health outcomes. CDC initiated a review of the strategic plan and has contracted with RTI to develop new outcome measures. The measures may compare the program clients with similar populations. For example, one measure that could be considered is to focus on the morbidity and mortality of the eligible population.

Evidence: The program has entered into a contract with RTI to develop these new outcomes goals.

3.1 Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance? Answer: Yes Question Weight: 9%

Explanation: CDC collects data from a variety of sources and currently three reporting mechanisms are in place: System for Technical Assistance Reporting (STAR), which collects management and infrastructure data (submitted by grantees once per year); minimum data elements (MDEs) (submitted twice a year), which monitor clinical outcomes, and Program Progress Review (once per year), which is a list of financial/program indicators that CDC developed to assess program progress. CDC conducts site visits at least once a year, and also constantly monitors data. When the data illustrates a problem, CDC will intervene.

Evidence: The data collected from the various reporting mechanisms allowed CDC to make a radical change in the program approach to cervical cancer. From the data, it was apparent that rescreening women who have consistently regular Pap results can often cause more harm than good by increasing anxiety. Scientific evidence has proven that 60% of invasive cervical cancers occur in people who have not been screened. Therefore, the policy shift went from trying to rescreen consistently normal Pap to recruiting never or rarely screened women. CDC also looks at the MDE system and if states arent meeting these standards, they will investigate.

3.2 Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results? Answer: No Question Weight: 9%

Explanation: Federal managers are accountable for cost and schedule, but not for achievement of program performance goals. The program has performance requirements related to execution and management of the program. Only SES in the overall Chronic Disease Center, not the breast and cervical cancer program, have performance-based contracts. The Chronic Center is planning to move this system downwards to the program directors. Partners are held accountable for cost, schedule and performance results.

Evidence: One of the SES managers performance goals: diagnosing at least 70% of women aged 40 and older with localized stage for breast cancer. For grantees, the program has established Program Process Indicators that are used to assess how well grantees are performing, through primarily process measures. If grantees do not meet their proposed objectives, the program will restrict their funding. CDC has reallocated grantee funds when the program is not performing.

Program: Chronic Disease - Breast and Cervical Cancer
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	64%	25%	

3.3 Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: Yes Question Weight: 9%

Explanation: CDC usually obligates all funds within a timely manner; CDC-wide policy is that a program must obligate its funds within the next budget year. CDC's procurement and grants office undertakes a reconciliation process at the end of the year to ensure that the program has spent funds consistent with their proposed budgets. The program also undertakes a review of the expenditures at the end of the year.

Evidence: The unobligated balances of the program's grantees is less than 10%.

3.4 Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: No Question Weight: 9%

Explanation: CDC does not have incentives/procedures in place to measure and achieve efficiencies and cost-effectiveness. The program has created several reporting mechanisms to streamline the data collection process, which is geared toward improving efficiencies. The program is initiating internal meetings to identify actions that can be undertaken to enhance the program's cost effectiveness and cost efficiencies. Additional steps, including adoption measures of efficiency of operations, are appropriate.

Evidence: Efficiency: CDC is working on an electronic version of the MDEs, which is almost completely automated and has just made the STAR system electronic. The MDE helps strengthen NBCCEDP outreach efforts by monitoring clinical outcomes of the program.

3.5 Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels? Answer: Yes Question Weight: 9%

Explanation: CDC includes in its program the total costs, including overhead. Since most of the money is used for screening services, there is a direct link between funding levels and program performance.

Evidence: Each program line in the CDC's budget includes extramural, intramural and all overhead costs.

3.6 Does the program use strong financial management practices? Answer: No Question Weight: 9%

Explanation: The FY 2002 report noted reportable conditions relating to information systems; the internal controls over preparation, analysis and monitoring of financial information, including manually intensive procedures; reimbursable agreements; and grants accounting and oversight. None of the reportable conditions are considered material internal control weaknesses. CDC has actively addressed key areas. CDC automated reimbursable billings, enhanced year end closing transactions and implemented a new indirect cost methodology. CDC is also addressing staffing needs, including core accounting competencies, professional staff recruitment, financial systems, training and customer service.

Evidence: Evidence includes the FY 2002 Chief Financial Officers annual report, including summary of reportable conditions, summary documents on end of year balances, OIG reports (e.g., CIN-A-04-98-04220). Four areas of findings were also documented the prior year. CDC has received five consecutive unqualified opinions on the agency's financial statements. Additional data include that CDC issued 64 duplicate or erroneous payments in FY 2002, or 0.042% of all payments and has a 97% compliance rate for prompt payments.

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Breast and Cervical Cancer
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	64%	25%	

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: Yes Question Weight: 9%

Explanation: As noted above, the agency is actively addressing financial managment. The program is trying to move performance-based contracts down to the division level, and is trying to improve efficiencies through making more of its systems electronic. The program is also initiating new internal meetings on potential improvements in program efficiency and cost effectiveness. The program is working with state health departments to determine what performance information can be made available to the public. Information on numbers screened, diagnosed, abnormalities, and other factors of program performance and accomplishment from the state level are to be made public. A new negotiated plan is to be in place by the end of 2003. The program is also working with health economists to improve the assessment of efficiencies and cost effectiveness in program execution.

Evidence: Evidence includes the revised submission.

3.CO1 Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process? Answer: Yes Question Weight: 9%

Explanation: CDC currently funds all 50 states based on a technical review process.

Evidence: The technical review is carried out by CDC project officers to make sure that grantees are meeting their states objectives.

3.CO2 Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process? Answer: Yes Question Weight: 9%

Explanation: All 50 states currently receive funding; however, they must recompete for funding every five years and there are also new tribal organizations who are eligible for CDC's funding.

Evidence: Grants are ranked based on specified evaluation criteria.

3.CO3 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: Yes Question Weight: 9%

Explanation: Grantees are required to use a number of data collecting systems to ensure they are submitting up-to-date, accurate, and complete information to the CDC regarding their activities. CDC has developed annual program progress indicators that grantees must report on that helps them assess the performance of its grantees. These indicators include both process (financial, management) and more outcome-oriented measures (target screening rates) that CDC uses to check the status of its grantees. CDC has conference calls/ meetings -- in meeting objectives and performance measures with CDC staff during regular conference calls and/or site visits.

Evidence: These systems include STAR, MDEs, PPI and site visits. The information gathered is used to ensure grantee accountability and to assess funding and performance. Collection and review of MDE data occur twice a year. CDC indicates that the data gauges program performance and indicates when technical assistance is needed.

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Breast and Cervical Cancer
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	64%	25%	

3.CO4 **Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: No Question Weight: 9%

Explanation: The program collects performance data on an annual basis and the data is available to the public in aggregate form with select grantee activities highlighted. Information on individual grantee performance is not readily available publicly because CDC must receive permission from the state to publish its medical data. As described above in Question 7, CDC is taking additional steps to make state level performance information available to the public.

Evidence: The grantee must report to the CDC regularly using the STAR system, MDEs, Program Performance Indicators, quarterly reports and other methods, and the program collects data on demographic and screening information twice a year. The program provides aggregate performance data through its GPRA plan, the Internet, and publications.

4.1 **Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?** Answer: No Question Weight: 25%

Explanation: CDC is developing new long-term outcome goals with the assistance of a contractor. Once the goals are in place, the program will be able to track progress toward achievement of long-term health outcomes.

Evidence: Evidence includes the revised submission.

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: Large Extent Question Weight: 25%

Explanation: CDC has overachieved its target in several instances because the GPRA targets were developed based on earlier data and the results were based on data provided later in the year. CDC updated its targets for the FY 2004 Congressional Justification. A Large Extent is given because no long-term outcome goals meeting the standard of the assessment are in place at this time.

Evidence:

4.3 **Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?** Answer: No Question Weight: 25%

Explanation: Some of the data systems are electronic, which helps the program identify problems quickly. CDC also believes that some of its performance goals are efficiency goals, including increasing the percentage of women who receive a final diagnosis within 60 days of screening, and increasing the percentage of women with breast cancer who start treatment within 60 days of diagnosis. They have made progress on these goals over the years. The cost per service is held to the Medicare rate, so they cant charge above that rate. Additional efforts described in Section III may provide additional documented improvements in program efficiency in the future.

Evidence:

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Breast and Cervical Cancer
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	64%	25%	

4.4 Does the performance of this program compare favorably to other programs with similar purpose and goals?

Answer: N/A

Question Weight: 0%

Explanation: CDC indicates that it's breast and cervical cancer screening program is not similar to other programs, both because of the population it serves and the follow-up screening services provided. They have compared their screening services to private providers and found that they are roughly comparable in terms of abnormal findings, as well as internationally. Medicaid and Medicare provide insurance for screening services, which could be comparable, but data for both of these programs is not readily available. CDC currently serves about 15% of its eligible population and could serve more if additional resources were available.

Evidence:

4.5 Do independent and quality evaluations of this program indicate that the program is effective and achieving results?

Answer: Small Extent

Question Weight: 25%

Explanation: While the program has had several evaluations looking at particular components of the program, and some indicate that CDC's program has supported services comparable in quality to those provided elsewhere, there havent been any comprehensive evaluations that look at how well the overall program is achieving performance results. The program has multiple evaluations in progress focused on specific topics that may provide additional insight on program effectiveness in the future.

Evidence: Studies indicate that the quality of data provided through the minimum data elements system and the linkages between women who have been screened through the program and treatment services is quite good, and women who were diagnosed received follow-up services in a timely fashion.

PART Performance Measurements

Program: Chronic Disease - Breast and Cervical Cancer

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Percentage of all newly enrolled women who have not received a Pap test within the past five years.

Additional Information: Performance Target: FY 2004: 22.5% over FY 2000 baseline of 21.7% Actual Performance:FY 2001: 23.3%

Year	Target	Actual	**Measure Term:**	Annual
2000		21.7%		
2001		23.3%		
2004	22.5%			

Measure: Percentage of women with breast cancer and cervical cancer who start treatment within 60 days of diagnosis.

Additional Information: Performance Target: FY 2004: Breast: 95% over FY 2000 baseline of 94%; Cervical: 90% over baseline of 88% Actual Performance:FY 2001: Breast: 93.1%; Cervical: 88.5%

Year	Target	Actual	**Measure Term:**	Annual
2000		94%/88%		
2001		93.1%/88.5%		
2004	95%/90%			

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Diabetes
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	60%	33%	

1.1 Is the program purpose clear? Answer: Yes Question Weight: 20%

Explanation: This program's mission is to eliminate the preventable burden of diabetes through leadership, research, programs, and polices that translate science into practice.

Evidence: Strategic Plan Mission.

1.2 Does the program address a specific interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: This program focuses on reducing the health complications due to diabetes (secondary/tertiary prevention) through support of state diabetes control programs. Despite the benefits of health screenings such as eye exams, foot exams, and the monitoring of blood glucose for people with diabetes to help delay/prevent the onset of complications (e.g., diabetes-related blindness, end-stage renal disease, and lower-extremity amputations), many people still do not receive these health services. The program does not directly support screening services (which CDC did previously and only reached about 2-3% of the population), but instead works with organizations within states to encourage the provision and use of these services to reach a larger proportion of the population, and supports states efforts to define the burden of diabetes. Last Fall, there was a study indicating that people with pre-diabetes could be prevented from developing diabetes through specific interventions; CDC is now working to incorporate some primary prevention into its program.

Evidence: Diabetes is the 6th leading cause of death in the U.S. Approximately 17 million people in the U.S. have diabetes and the number of persons with diabetes is projected to increase by 1 million people/year. Diabetes cases increased 49% from 1990-2000. The average health care cost in 1997 was $10,071 per person with diabetes, compared to $2699 without the disease. Each year, 12,000-24,000 people become blind because of diabetes-related eye disease; screening can help prevent up to 90% of the cases of eye disease. Approximately half of the new cases of diabetes related kidney failure and lower extremity amputations could be prevented each year through targeted interventions, yet screenings are not provided uniformly to all people with diabetes. One example of a successful comprehensive diabetes control program is in Minnesota. Since 1994, participants risk for diabetes-related heart problems has declined by 40% and their risk for eye and kidney disease has declined by 25%.

1.3 Is the program designed to have a significant impact in addressing the interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: CDC is the only entity providing Federal support for statewide partnerships and systems to help reduce the complications of diabetes. CDC leverages funds by requiring a 1: 3 match for comprehensive programs and a 1:5 match for core programs (primarily in-kind contributions). Federal dollars for this program totaled $62 M in FY02 and the state matching requirement totaled approximately $12 M.

Evidence: Program supports state health departments efforts to implement state diabetes control programs and bring together various partners statewide to reach the majority of the population (85% through the comprehensive programs). The program works with organizations that provide screenings and works to ensure that both the public and providers know about the importance of these services. CDC's core programs (34 states at $232K) support 2-3 demonstration partnerships with managed care organizations or health groups to lay the foundation for statewide programs. The comprehensive programs (16 states at $800K) have a statewide presence to increase awareness about the problems of managing diabetes, influence the health systems to improve care and increase the impact of the program.

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Diabetes
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	60%	33%	

1.4 Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)? Answer: Yes Question Weight: 20%

Explanation: CDC is the primary convener of diabetes-related programs in the country working through state health departments. State and other non-governmental organizations have not historically played a role in diabetes prevention. CDC has helped leverage additional state dollars through the matching requirement and by providing funding for these types of activities.

Evidence:

1.5 Is the program optimally designed to address the interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: Direct Federal provision of these services does not make sense since it would require a lot of staff. CDC utilizes a cooperative agreement (vs. grant) mechanism to ensure a flexible yet accountable approach to the diabetes epidemic.

Evidence: A cooperative agreement requires more federal involvement in carrying out the program than a grant does. The states are responsible for determining which CDC-prescribed diabetes activities within their states will help minimize the burden of diabetes. The CDC will provide ongoing guidance, technical assistance and consultation to the grantees for support.

2.1 Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program? Answer: Yes Question Weight: 14%

Explanation: The program has proposed new long-term outcome measures. CDC will focus first on lower extremity amputations. CDC plans to develop a statistical computer model to predict the number of cases of blindness, amputations and kidney disease over a 10, 15, and 20 year time span. The models are to enable CDC to establish scientifically credible targets. Determining how to confirm progress on these targets is still under review.

Evidence: The measures include, by 2010: Reduce the rate of lower extremity amputations in persons with diabetes to 1.8 lower extremity amputations per 1,000 persons with diabetes. After the model is complete for lower extremity amputations, CDC intends to develop an outcome measure for end-state renal disease. For example, CDC tracks Healthy People 2010 measures to reduce kidney failure due to diabetes to 78 diabetic persons per million population. CDC intends to have the model for lower extremity amputations completed for use in the measure by June 2004. With new baseline information, targets may be adjusted at that time. A model for end-stage renal disease will be available the following year.

2.2 Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals? Answer: Yes Question Weight: 14%

Explanation: CDC has annual performance goals that mirror its long-term outcome goals. The GPRA goals currently track annual progress of the comprehensive programs, and tend to meet or exceed the overall national goals. The program plans to annually track progress on a national level, and will incorporate these national annual goals into its GPRA plan next year. CDC requires grantees to report on these performance measures every year. CDC has also added an outcome-oriented performance measure for its core programs in this plan. While CDC has developed two annual goals that focus on primary prevention, these are contingent on additional resources.

Evidence: For the comprehensive programs, the GPRA annual goals are: 1. Increase the percentage of persons with diabetes who receive annual eye and foot exams from 61.7% for eye to 72% and for foot from 52.4% to 62% in FY 2002. 2. Increase the % of persons w/ diabetes who receive at least 2 A1c measures per year from 62.5% to 72.5%.

Program: Chronic Disease - Diabetes
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	60%	33%	

2.3 **Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?** Answer: Yes Question Weight: 14%

Explanation: Currently, grantees must report on progress towards the six Healthy People 2010 goals and report annually on the number of foot exams, eye exams, etc. In CDC's new grant announcement, states will have to set quantifiable targets that will help CDC achieve national targets, and CDC will negotiate a target goal with the individual state that will help CDC achieve its overall goals.

Evidence: Grantees must include this information in grant applications. A management information system has been created recently to collect and analyze data from program partners annual reports. This system provides consistent information on programmatic activities and strengthens the program's ability to gauge partners progress in achieving goals.

2.4 **Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?** Answer: Yes Question Weight: 14%

Explanation: CDC coordinates with CHCs at the state level, and has formal MOUs with NIH, VA, CMS and IHS. CDC works with these programs to provide technical assistance since they are interested in improving the quality of care. The DCP also has partnerships with various agencies such as state health departments, community health organizations, hospitals and health systems, local health departments, nonprofit organizations, PCPs, academia, peer review organizations, and MCOs.

Evidence:

2.5 **Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?** Answer: Yes Question Weight: 14%

Explanation: The diabetes program has had its entire program evaluated at fairly regular intervals and has also evaluated program-specific areas including a training program and the diabetes flu campaign. CDC has contracted with OCR Macro to conduct an evaluation of the national program. The initial emphasis will be on process, grantee performance, effects of program intervention models and system changes that reduce the burden of diabetes.

Evidence: Batelle conducted a study in 1993 and 1997 to evaluate the program after it had undertaken new activities. In 1998, a study was undertaken to evaluate innovative practices in diabetes care used by CDC's grantees. From 1999-present, Macro International has been providing technical assistance to measure the program goals and accomplishments.

2.6 **Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?** Answer: No Question Weight: 14%

Explanation: While CDC does try to set its goals and then budget based on these goals, the budget is not explicitly aligned with the program goals so that it is clear how much funding is required to achieve the specified program goals. There is no specific cost per unit service that would indicate how much funding would be required to reach the program's goals. However, CDC does track its budget by surveillance, research, program and communications, which helps it track the impact of its individual programs.

Evidence:

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Diabetes
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	60%	33%	

2.7 **Has the program taken meaningful steps to address its strategic planning deficiencies?** Answer: Yes Question Weight: 14%

Explanation: CDC is working to develop long-term health-outcome measures. CDC is also working to improve budget alignment through use of the management information system.

Evidence: Evidence includes the revised submission from the program.

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: Yes Question Weight: 10%

Explanation: The diabetes program collects performance information through annual continuation applications and semi-annual progress reports. The program also collects information through regular site visits and conference calls. The Diabetes Management Information System (MIS) provides individual DCP performance and strategic direction over time.

Evidence: The program has taken information received from the MIS and used it to revoke grantees funding because they had not taken adequate steps to change their spending patterns.

3.2 **Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?** Answer: No Question Weight: 10%

Explanation: Federal managers are held accountable for cost and schedule but not for program performance results. Grantees are held accountable for cost, schedule, and performance, and past performance is taking into consideration when allocating grantee awards.

Evidence: Federal: Only CDC SES managers have performance-based contracts but there are no SES in the diabetes program, and only a few in the overall chronic disease division. CDC is looking at moving these contracts into the lower ranks. CDC managers are evaluated based on how well they implement and execute the program. Grantee: When a program moves from a core to a comprehensive grant, past performance is taken into consideration when allocating a grant award.

3.3 **Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: Yes Question Weight: 10%

Explanation: Both the program and its partners generally obligate funds within a timely fashion, and the diabetes program monitors how the grantees funds are spent closely through both site visits and the diabetes MIS system.

Evidence: Obligations: CDC obligates about 99% of its funds while its state grantees obligate 90-95% of the funds by the end of the year. A very small minority of grantees have unobligated balances. CDC monitors state expenditures, and if there are problems, they provide technical assistance and may decrease the total award. Intended Purpose: Site visits are conducted twice a year with at least one visit consisting of a review of expenditures of grantees with a state financial officer.

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Diabetes
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	60%	33%	

3.4 **Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: Yes Question Weight: 10%

Explanation: The diabetes program has a relatively small staff so it outsources many of its activities. CDC is undertaking a formal management analysis of its processes to determine how they can operate more efficiently and shorten the amount of time it takes to complete tasks. In the past, they have conducted a "state of the branch" annual report to help evaluate its operations. CDC has developed an MIS system that all states are now connected to that provides constant information to CDC on grantee budget and program activities. Additional steps, including adoption measures of efficiency of operations, are needed to maintain progress in this area.

Evidence:

3.5 **Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?** Answer: No Question Weight: 10%

Explanation: While CDC estimates for the full annual costs of operating the program, there is not a precise link between this funding and the achievement of performance goals.

Evidence: Each program line in the CDC's budget includes extramural, intramural and overhead costs.

3.6 **Does the program use strong financial management practices?** Answer: No Question Weight: 10%

Explanation: The FY 2002 report noted reportable conditions relating to information systems; the internal controls over preparation, analysis and monitoring of financial information, including manually intensive procedures; reimbursable agreements; and grants accounting and oversight. None of the reportable conditions are considered material internal control weaknesses. CDC has actively addressed key areas. CDC automated reimbursable billings, enhanced year end closing transactions and implemented a new indirect cost methodology. CDC is also addressing staffing needs, including core accounting competencies, professional staff recruitment, financial systems, training and customer service.

Evidence: Evidence includes the FY 2002 Chief Financial Officers annual report, including summary of reportable conditions, summary documents on end of year balances, OIG reports (e.g., CIN-A-04-98-04220). Four areas of findings were also documented the prior year. CDC has received five consecutive unqualified opinions on the agency's financial statements. Additional data include that CDC issued 64 duplicate or erroneous payments in FY 2002, or 0.042% of all payments and has a 97% compliance rate for prompt payments.

3.7 **Has the program taken meaningful steps to address its management deficiencies?** Answer: Yes Question Weight: 10%

Explanation: As noted above, the agency is actively addressing financial management. The program is working to move the performance-based contracts down to the division director level over the next year or two. The program is taking steps to make newly available information from BRFSS on state performance available on the internet by October 2003.

Evidence: Evidence includes the revised submission.

Program ID: 10000290

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Diabetes
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	60%	33%	

3.CO1 **Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?** Answer: Yes Question Weight: 10%

Explanation: CDC currently funds all 50 states based on a technical reviews by an internal CDC (outside program) objective review panel. When the program moves from a core to comprehensive grant, it must demonstrate evidence of past performance. Every 3-5 years comprehensive programs have to recompete for funding.

Evidence: The technical review is carried out by CDC project officers to make sure that grantees are meeting their states objectives. Awards are made based on the results of the objective review process.

3.CO2 **Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?** Answer: NA Question Weight: 0%

Explanation: Currently all 50 states receive some sort of funding.

Evidence:

3.CO3 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: Yes Question Weight: 10%

Explanation: CDC requires annual and semi-annual reports, two site visits/year (a financial officer is present at least one of those meetings), and monthly conference calls. In addition, CDC can receive information about grantee activities regularly through its MIS program.

Evidence: Included in the reports are status of the programs progress toward meeting the national objectives.

3.CO4 **Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: No Question Weight: 10%

Explanation: As of now, CDC does not readily have information available on all grantees individual performance. CDC does collect information on an annual basis and select information is made available to the public highlighting certain states activities through published reports and the Internet. However, for the first time in 2002, CDC grantees reported performance information through BRFSS to the program related to achieving national program goals. CDC plans to make this information available on the website.

Evidence: The public can access individual state data on certain performance measures based on the Behavioral Risk Factor Surveillance System. Some performance data is also aggregated at a national level and is included in the GPRA plan.

4.1 **Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?** Answer: No Question Weight: 25%

Explanation: CDC is developing new outcome measures. As a result, the program will be able to track progress toward meeting these long-term health outcomes.

Evidence: Data are not yet available to indicate progress.

Program Assessment Rating Tool (PART)

Program: Chronic Disease - Diabetes
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	86%	60%	33%	

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: Large Extent Question Weight: 25%

Explanation: The program has made strong progress towards meeting its existing annual goals, but does not yet have data available yet to indicate progress on some of its new measures.

Evidence:

4.3 Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year? Answer: Small Extent Question Weight: 25%

Explanation: Most of the diabetes program's accomplishments include reducing administrative burdens for grantees through moving to an electronic-based reporting system (system went online in June, 2002). The program indicates that this is expected to improve its own efficiency by 200-500% for activities such as generating the number of hours it takes to generate the reports by having this system in place. The program indicates that his will help them interface quickly with grantees when a problem is detected. A new application to be released in FY 2003 is to further reduce the application and reporting burden of grantees. CDC is to document these improvements.

Evidence: Evidence includes the program's revised submission.

4.4 Does the performance of this program compare favorably to other programs with similar purpose and goals? Answer: N/A Question Weight: 0%

Explanation: The diabetes program is not similar, in its role as convener and partner to many different health care providers, to any other program.

Evidence:

4.5 Do independent and quality evaluations of this program indicate that the program is effective and achieving results? Answer: Small Extent Question Weight: 25%

Explanation: The external evaluations have indicated that the program's activities have made an impact in reducing complications due to diabetes. However, since most of the evaluations have focused on program improvements, not performance results, these evaluations have not measured the program's progress in achieving its performance goals.

Evidence:

PART Performance Measurements

Program: Chronic Disease - Diabetes

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Rate of lower extremity amputations in persons with diabetes.

Additional Information: Target:2010: 1.8 lower extremity amputations per 1,000 persons with diabetes per year. Actual Progress achieved toward goal:No data available

Year	Target	Actual	**Measure Term:** Long-term
2010	1.8 per 1,000		

Measure: Percentage of people with diabetes who receive the recommended eye and foot exams in States with comprehensive diabetes control programs funded by the program.

Additional Information: Performance Target: Eye - from 67.3% in FY 1999 to 72% in FY 2002; Foot - from 57.8% in FY 1999 to 67% in FY 2002. Actual Performance:FY 2001: Eye - 69.8% and Foot - 62%

Year	Target	Actual	**Measure Term:** Annual
1999	72%/62%	67%/58%	
2000	72%/62%	69%/62%	
2001	72%/62%	70%/62%	
2004	72%/67%		
2004	72%/67%		

Measure: Percentage of persons with diabetes who receive at least 2 blood sugar control measures per year in States with comprehensive diabetes control programs funded by the program.

Additional Information: Performance Target: From 62.5% in FY 2000 to 72.5% in FY 2004. Actual Performance: 2000 62.0% and 2001 63.3%

Year	Target	Actual	**Measure Term:** Annual
2000		62.0%	
2001		63.3%	
2004	72.5%		

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The purpose of the Community Mental Health Services Block Grant is to provide flexible funds to states and territories by formula to support community mental health services for adults with serious mental illness and children with serious emotional disturbance. Funds are provided to state mental health agencies, which have primary responsibility for operating the public mental health system. The block grant is designed to provide resources to states to help them implement state plans to improve community-based services and reduce reliance on hospitalizations for the treatment of mental illness. The target population are those with serious illness and not those with mild disorders or those at risk of developing future disorders. Five percent of the total is used by the agency for technical assistance, data collection and other activities. The block grant funds state infrastructure to support care and treatment in the community and not only direct services.

Evidence: The block grant is authorized in section 1911 to 1920 of the Public Health Service Act. The authorization specifies eligibility, criteria for allocating resources, the content of state plans for use of funds, maintenance of effort and the establishment and maintenance of the State Mental Health Planning Council. Community mental health centers provide the majority of services funded by the block grant. Agency and Congressional reports related to the program are consistent with the program purpose as outlined in the authorizing legislation. The program was established in 1981 as the Alcohol, Drug Abuse and Mental Health Services block grant. The program is run by the Substance Abuse and Mental Health Services Administration (SAMHSA).

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The block grant addresses the problem of providing comprehensive, community-based systems of care for individuals with serious mental illness and serious emotional disturbance who rely primarily on public mental health systems for their care. Over time, states have shifted care of people with serious mental illness from institutions to the community. The block grant is focused on services for those reliant on public mental health systems and is designed to provide resources to enable individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. To work most effectively, the mental health service system should coordinate with many sectors, including public and private care, specialty care, social welfare, housing, criminal justice, etc. (Mental Health: A Report of the Surgeon General, 1999). States must address coordination in their state plan. Through this process, the block grant is designed to address the state-wide system.

Evidence: Of the 10 million adults who meet the criteria for serious mental illness in any given year, between 50 and 60 percent receive treatment. An estimated 4.5 to 6.3 million children in the United States have a serious emotional disturbance. An estimated 75-80% of children with serious emotional disturbance are not receiving specialty mental health services. The 1999 Surgeon General report on mental health found children with serious emotional disturbance are best served with a systems approach (SGR, 1999). Most users receive some care in private facilities and a fifth receive care in public facilities. Of the minority using inpatient care, a third receive care in public facilities (SGR). State mental health agencies are responsible for service delivery for more than 2 million people suffering from serious mental illness each year; data from 33 states indicate state agency expenditures for psychiatric hospitals dropped from 52 percent to 35 percent of total expenditures between 1987 and 1997 (GAO-01-224).

Program ID: 10001061

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: The mental health block grant is not overly redundant or duplicative of other efforts. Traditionally, the public mental health system has been operated and funded by state and local government. The federal government has increased its involvement in this area of effort over time through Medicare, Medicaid and targeted federal funding. However, the block grant is the only federal program that provides funds to every state to develop a comprehensive, community-based system to provide services to persons with severe mental illness who are uninsured or insured but have no mental health coverage. The block grant allotment makes up between less than one percent and as high as 33 percent of each state's mental health agency expenditures, including Medicaid. The block grant also requires states to develop plans to coordinate all sources of funding.

Evidence: Evidence includes GAO-01-224. In addition to the block grant, federal programs involved in supporting mental health services today include Medicaid, Medicare, SAMHSA competitive mental health grants, SAMHSA's PATH state formula grant for homeless individuals with serious mental illness and SAMHSA's Children's Mental Health Services program. Medicaid accounted for 20 percent of all mental health spending in 1997. Medicaid covers medically necessary services and some social support services for persons with mental illness. The block grant supports services for those ineligible for Medicaid and supportive services such as employment and housing that Medicaid does not reimburse. According to a NASMHPD survey of 37 states, people served with block grant funds represent 24 percent of all persons served in the public mental health system. Plans must address health and mental health, substance abuse and other supportive services such as employment and housing to be provided to individuals with mental illness through federal, state and local funds.

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: The block grant is free from major design flaws that prevent it from meeting its defined objective of supporting state efforts to move care for adults with serious mental illness and children with serious emotional disturbance from inpatient care to the community. The agency is reviewing approaches to shift the program emphasis from set-asides and other state funding requirements to reporting on the outcomes of grant expenditures. The agency seeks to retain the prevention set-aside and other requirements such as screening for tuberculosis. While there are possible flaws to the distribution of funds described below, there is no strong evidence that another approach or mechanism such as competitive grants would be more efficient or effective.

Evidence: Evidence includes the draft report to Congress on transforming block grants in performance partnerships (April 2003). As initially designed, the block grant was intended to simplify federal restrictions and oversight on funds, reduce administrative expenses, increase flexibility and state authority, strengthen state capacity, increase and maintain service system capacity, allocate funds equitably and target funding to priority issues. Statute and regulations require states to report how they spent their grant funds and do not require reporting on the impact the funds have on individuals or targeted populations. By design, an emphasis on reporting on the outcomes of federal expenditures was not included.

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: A strong correlation between funding distribution and prevalence is an important aspect of program targeting and improves the chances that individuals will have the same probability of getting care regardless of where they live. While the formula does not use prevalence of serious mental illness and serious emotional disturbance, agency data indicate little variation in serious mental illness by state and region, making the lack of prevalence data in the formula less meaningful. Prevalence does vary by age, gender, educational status, and urban and rural residence. In the case of serious emotional disturbance, prevalence correlates with poverty rates, which are not incorporated into the formula, but are indirectly captured by wage data. Wage data are an indirect measure and often out of date and poverty data may be more useful. State surveys confirm the block grant serves low-income individuals with serious mental illness and the maintenance of effort requirement guards against supplantation.

Evidence: The estimated 12 month prevalence of serious mental illness is between five and six percent nationally and rates do not differ among states at a 95 percent confidence interval (Federal Register 6/24/99). SAMHSA published additional definitions and data methods for serious mental illness and serious emotional disturbance (FR 5/20/93, 7/13/98). A 1995 RAND evaluation highlighted some equity shortcomings. A more narrow focus, such as the poor and uninsured, rather than age, may better serve equity goals and program purpose (RAND, MR-533-HHS/DPRC, 1995). The HHS Office of the Inspector General notes block grants often include targeting requirements for vulnerable populations, but effectiveness is unproven (OIG, OEI-01-94-00160). Prior to the most recent reauthorization, states called for an external review of the block grant formula by the National Academy of Sciences or another independent body. The 2000 reauthorization established a minimum allotment. The formula uses taxable resources, population size and age, cost of services and wage data. HHS adjusts the formula every three years.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation: The agency adopted new long-term outcomes measures to advance strategic planning and the conversion of the block grant to a performance partnership grant. Measures include: Rate of readmission to State psychiatric hospitals (a) within 30 days (b) within 180 days; and, Rate of consumers/family members reporting positively about outcomes.

Evidence: This first measure captures efforts to move people from state hospitals to community care; develop transition/discharge-planning systems; and establish comprehensive community-based care systems. Readmission is useful as an indicator of the desired outcome of developing a community-based system of care. Reporting on outcomes captures whether the person is better able to deal effectively with daily problems, control their life, deal with crisis, get along with family, do better in social situations, do better in school and/or work, and is bothered less by symptoms. All sixteen states do not report on each measure, and there are further variations for those that are reporting. Under the performance partnership grants, states will report on performance against agreed upon outcome goals. A notice in the December 24, 2002 Federal Register describes central elements of the proposed transition to performance partnership grants.

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation: The program has baselines and targets for the long-term measures.

Evidence: The program has baseline data from 2000 for the first measure with a target year of 2008. The program has baseline data from 2002 for the second measure with a target year of 2008.

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?

Answer: YES Question Weight: 12%

Explanation: The agency has a limited number of annual measures that can demonstrate progress toward achieving desired long-term outcomes. Annual measures include: the number of people served by state mental health systems, the number of SAMHSA-identified, evidence-based practices adopted in each State and the percentage of (service) population covered, and annual increments of the two long-term outcome measures on readmission and consumer reported outcomes.

Evidence: The number of persons served captures the reach of the program. The evidence-based practices measure captures the agency's efforts to improve the efficiency and effectiveness of state-supported mental health services. The annual measures for readmission and outcomes will provide the program regular updates on progress toward meeting the long-term measures.

2.4 Does the program have baselines and ambitious targets for its annual measures?

Answer: YES Question Weight: 12%

Explanation: The agency has baseline and targets for all but one of the annual measures.

Evidence: Initial baseline data for the evidence-based practices measure will be obtained in December 2003 through the program's URS and the remaining areas will be reported on in 2004. A pilot study will be conducted in FY 2005 on the relationship between evidence based practices and cost for baseline data.

2.5 Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?

Answer: YES Question Weight: 12%

Explanation: Program managers work to ensure states support the overall goals of the block grant and measure and report on performance as it relates to accomplishing goals. Beginning this year, 50 states are reporting on performance information through basic and developmental tables of the uniform reporting system. States also commit to the overall objectives of the block grant to provide community-based services when possible to adults with serious mental illness and children with serious emotional disturbance. States include descriptions of how they will meet overarching goals of the program in state plans and reports. The block grant has gone through an important transition over time from a formal application review process to more of a partnership. States are involved in the setting of goals through planning for the transition to performance partnership grants. Commitment toward the goals of the program should increase further through this transition in coming years.

Evidence: States and territories include needs assessment data in their applications and are now reporting on performance information. According to SAMHSA, the program has worked with states since its inception to improve data collection and reporting. An example of these efforts is the 16-State Project to develop uniform data and unduplicated counts of persons served. Forty-seven States have also received grants to improve data collection. A notice in the December 24, 2002 Federal Register describes central elements of the proposed transition to performance partnership grants. The state implementation reports and block grant plans already provide considerable information and commitments. The agency has also laid the groundwork for implementing new outcome measures that will enable partners to commit to and work toward the annual and long-term goals of the program.

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?**

Answer: YES Question Weight: 12%

Explanation: A Yes requires regularly scheduled objective, independent evaluations that examine how well the program is accomplishing its mission and meeting its long-term goals. The program is initiating the first of three consecutive independent evaluation studies in FY 2003. The first study will assess whether the program is working in a logical way, examine how to collect data on effectiveness, and make recommendations for program improvements. A second study in FY 2004 will be more comprehensive and will test performance indicators and examine specific program deficiencies. A final summative evaluation in FY 2005 will assess the impact of program changes made following recommendations from the first assessment. As noted in Section IV, no comprehensive and external evaluations have been completed to date on this program. By design, accountability and evaluations have been focused on compliance with statute, including set-aside requirements.

Evidence: The three studies will range from $100,000 to $1 million in cost and will be conducted by external groups through contracts. SAMHSA reports grantee efforts for evaluation, but no independent, comprehensive evaluations of the program are available. Many states also conduct evaluations, but they are not currently aggregated or reported on at the national level. RAND conducted an evaluation of the funding formula in 1995 (RAND, MR-533-HHS/DPRC, 1995). NASMHPD published a review of state spending in March 2003, including per capita spending and expenditures by group. The organization has also published reports on psychiatric hospital discharge rates and institution closings, implementation of evidence based practices and a survey of 37 states on the profile of those being served and the type of services delivered.

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?**

Answer: NO Question Weight: 12%

Explanation: The program does not provide a budget presentation that clearly ties the impact of funding decisions on expected performance or explains why the requested performance and resource mix is appropriate. Annual budget requests are not clearly derived by estimating what is needed to accomplish long-term outcomes. The program has different output and outcome goals and has not identified how much cost is attributed to each goal. The program is currently able to estimate outputs (number of persons served) per increased increment of dollars by dividing block grant funding by average Medicaid client cost for outpatient care. The block grant supports 17 full time equivalent staff. Other agency program management funds are budgeted separately.

Evidence: This assessment is based on the annual budget submission to OMB and the Congress.

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

2.8 Has the program taken meaningful steps to correct its strategic planning deficiencies? Answer: YES Question Weight: 12%

Explanation: SAMHSA is currently undertaking a comprehensive strategic planning effort to address accountability, capacity, and effectiveness. The agency has formed a planning matrix of priorities and crosscutting principles to coordinate resource allocation across the agency and produced a draft strategic plan. The program plans to begin developing budget requests based upon average cost to serve a client in a community program. Having new measures in place will further enable the program to integrate budget planning and strategic planning and determine the level of financial resources needed to obtain long-term outcomes. The agency's efforts to develop a performance partnership grant will also facilitate commitment to and reporting on performance measures. The agency contracted with NASMHPD in 2002 to examine the ability to define and implement performance measures for the block grant. The report found promise but noted substantial work remains to make the measures comparable across states.

Evidence: The agency's restructuring plan consolidated budget formulation, planning and Government Performance and Results Act activities within one unit. As described in a December 24, 2002 Federal Register notice, the performance partnership grant is based on a shift toward greater accountability in exchange for state flexibility to design, implement, and evaluate mental health services. SAMHSA is currently working with the states to identify core measures for mental health services. With set-aside funding, the agency is also supporting a technical assistance center for evaluation of programs and systems to improve adult services under the block grant. State data infrastructure grants are being used to improve state data collection. SAMHSA indicates that it will pilot test an independent evaluation of several performance measures that will focus on multiple factors, including federal programs and funding streams and state and local resources. SAMHSA has developed an evaluation contract directed toward improving program evaluation in the block grant and other SAMHSA programs.

3.1 Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance? Answer: YES Question Weight: 11%

Explanation: The program collects performance information on an annual basis and uses the information to manage the program and improve performance. The states submit annual uniform applications that describe past, current, and intended use of program funds. The program collects annual information on state satisfaction with agency technical assistance and the grant review process. Program performance data are also collected during onsite technical reviews. SAMHSA also uses data from national surveys and contracts funded by the set-aside to guide technical assistance efforts.

Evidence: The assessment is based on agency descriptions of actions taken based on performance information, state annual reporting forms and plans, and annual budget documents submitted to OMB and the Congress. The program's Uniform Reporting System can help facilitate the transformation to a performance partnership grant to improve outcomes and focus on more effective services. The program updated the cost of services component based in part on findings from the 1995 RAND review of the formula.

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

3.2 Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?

Answer: YES Question Weight: 11%

Explanation: Performance plans for managers at the Division Director level and above track to management/program objectives. The program director is an SES level and has a performance contract. Managers review state compliance with the legislative requirements and monitor expenditures through compliance reviews and single audit reports, ensure that applicable financial status reports are completed, and reconcile financial status reports to the Payment Management System. Performance Based Contracting has been initiated for all new SAMHSA contractors who hold services contracts. The transition to performance partnership grants will increase the accountability of program partners for performance results.

Evidence: The assessment is based on discussions with the agency and manager performance contracts. Employee evaluations at the agency are handled by each of the agency's three centers. One planned element of the performance partnership grants is to use corrective action plans as a means of increasing accountability for performance results and making program improvements. The monitoring visits are one week on site reviews conducted by three consultants with fiscal, management and/or clinical expertise and a federal project officer. The review covers the state agency and two or more urban and rural programs serving adults and children. The program reserves the right by statute to withhold funds for failing to fully implement the state plan.

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?

Answer: YES Question Weight: 11%

Explanation: The agency reports funds are obligated by the government on a quarterly basis, usually within two-three days after an application has been determined compliant with relevant requirements of the Public Health Service Act. States have two years to obligate and expend funds to sub-recipients.

Evidence: Evidence includes application forms and agency documents. Agency managers review annual grantee applications to determine funds are used for the intended purpose. Agency staff also examine the states obligations and expenditures of grant funds during state technical reviews.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?

Answer: YES Question Weight: 11%

Explanation: The program has some procedures in place to improve efficiencies in execution. SAMHSA has established a block grant re-engineering team to improve the efficiency of staff operations in managing the program at the federal level. The agency does rely on an HHS service clearinghouse known as the Program Support Center for many internal services. The agency is providing FAIR Act targets and appears to be making progress toward outsourcing additional services. There are also elements in the block grant that seek to limit administrative costs. For example, there is a five percent limitation on administrative costs at both the federal and grantee levels. Each state and territory uses the fiscal policies that apply to its own funds for administering the block grant. Additional steps, including adoption of efficiency measures, are needed to maintain progress in this area.

Evidence: Evidence includes the FAIR Act report, services directed to HHS consolidated Program Support Center, and Restriction of Expenditure of Grant. In the area of technical assistance, the program provides assistance on the planning council requirements, children and families, criminal justice area, housing, and other topics primarily through contractors. In 2002-2003, 12 states received no assistance, 28 received one to two, 15 received three to five. Contractors include Bazelon, the National Alliance for the Mentally Ill, the National Association of State Mental Health Program Directors and others. The program also uses contracts for peer reviews and monitoring in the field.

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 11%

Explanation: The agency has transformed the relationship with states over time to a more collaborative exchange with respect to both the applications process and annual operations. Federal managers collaborate internally in SAMHSA, with other federal agencies, with national organizations and the states. At the state level, each grantee is required to have a mental health planning council to review the state mental health plan. The council must include consumers, family members, service providers and state officials. The state must also seek comments from the public on its plan.

Evidence: Evidence for this question is included in the Government Performance and Results Act report, meetings, conferences, and other documentation. Examples of specific activities include with CMS on Medicaid issues, with other agencies on the response to the Olmstead decision, with NASMHPD on the performance partnership grant planning, with states on the data infrastructure grant, with FEMA for crisis counseling and with the National Institute on Disabilities Rehabilitation and Research and DOE for research and training on children's issues.

3.6 Does the program use strong financial management practices? Answer: YES Question Weight: 11%

Explanation: The program receives clean opinions on its audits and is free of material internal control weaknesses. SAMHSA is participating in a department-wide initiative to implement a new Unified Financial Management System. SAMHSA will in the meantime replace the current DOS-based Integrated Financial Management System with a customized government-off-the-shelf system for tracking commitment and obligation data. The Integrated Resource Management System provides for tracking of commitments and obligations and for numerous management reports.

Evidence: Discussions and documents from agency managers, audited statements from the Program Support Center; Office of the Inspector General reports.

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 11%

Explanation: The program is taking meaningful steps to address management deficiencies in key areas. With respect to deficiencies highlighted in this section, the program has made performance information available from the sixteen state project on the Internet and will be able to make additional outcome data available to the public through the performance partnership grants. The program has also proposed a pilot study to test the cost efficiency of utilizing mental health interventions that have proven to be effective and the initial impact on expenditures. The program is addressing accountability for results at both the federal and grantee level. The agency has begun using performance contracts that will set specific, quantitative targets.

Evidence: The agency plans to implement performance plans for managers at the Division Director level and above that are tied to department-wide management objectives and agency program objectives in June. The agency plans to implement performance plans for all staff, which must include at least one element that tracks back to these objectives by September 30. The agency also plans to ensure program and management objectives in the SAMHSA Administrator's performance contract are incorporated into the performance plans of senior management and staffs. The Administrators performance contract is based on ten program priority areas that will eventually be incorporated into SES level, division level and branch chiefs. The use of performance measures in employee evaluations is under examination.

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

3.BF1 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: YES Question Weight: 11%

Explanation: The program does have sufficient oversight capacity. This capacity will improve with respect to outcomes of the block grant with the transition to performance partnerships. However, the program is able to document grantees use of funds in compliance with legislatively designated categories, conducts site visits to a substantial number of grantees on a regular basis and confirms expenditures in annual reports. Through national level relationships and the work of the project officers, the program has a fairly high level of understanding of what grantees do with the resources allocated to them.

Evidence: Evidence includes agency documentation, applications and the performance plans and reports. After reviewing the state plan implementation report for the previous fiscal year, the agency also reviews whether the state completely implemented the plan approved for the previous year.

3.BF2 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: NO Question Weight: 11%

Explanation: Grantee performance data are currently only available to the public at the national level and not disaggregated by state. The agency plans to make additional state information available in the near future from the Uniform Reporting System. Annual performance data are aggregated in the performance report and are available to the public through the SAMHSA web site. A conversion to a performance partnership grant will also increase the amount of information gathered on grantee performance on select outcome measures. Data from the 16-State Project are available to the public. Data are available by state and covering a number of areas, including readmission to psychiatric facilities, penetration of services and consumer reporting on access, appropriateness and positive changes resulting from services. Additional state information is available from the national association, but not through the agency.

Evidence: Assessment based on agency web site (www.samhsa.gov/funding/funding.html). Additional information is available through the National Association of State Mental Health Program Directors associated NASMHPD Research Institute (http://nri.rdmc.org/profiles.cfm) and from the sixteen state project at the Mental Health Statistics Improvement Program (http://www.mhsip.org/sixteenstate/index.htm).

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: As noted in Question 2 of the Strategic Planning section, the agency developed new long-term measures and adopted specific targets. The program has demonstrated progress in achieving outcomes related to these new measures in the annual performance plan. The related areas from existing measures that are to be dropped from the performance plan include improvements in employment, school attendance, stability of living arrangements, independent living and contact with the juvenile justice system. A small extent is given because the program does not yet have subsequent years of data to measure progress specifically on the long-term performance goals. The program will be able to measure progress in future years.

Evidence: Progress from existing measures include adult employment and contact with the criminal justice system from 1999 to 2000, improvements from 1999 through 2001 in independent living, improvements in school attendance from 2000 to 2001, improvements in stability of living arrangements from 1999 to 2001 and improvements in children's involvement with juvenile justice system in 2000 but not 2001. The program will collect additional data to show progress on the new long-term measures in the next year. Assessment based on agency planning documents, GPRA reports, SAMHSA-wide performance measures document and draft measures for the performance partnership grant. Twelve states are reporting on the percent of consumers reporting improved outcomes from services and 16 states are reporting on the percent readmitted within 180 days to any state psychiatric hospital.

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

4.2 Does the program (including program partners) achieve its annual performance goals?
Answer: SMALL EXTENT
Question Weight: 25%

Explanation: A Small Extent is given because the program does not have multiple years of data to show progress in achieving each of the newly adopted annual goals. The program will have additional data to measure achievement in future years. As noted in Question 4 of the Strategic Planning section, the agency has developed a baseline and adopted targets for all but one of the annual goals that support the desired long-term outcomes of the program.

Evidence: The number of persons served has increased when compared to 1992 and 1998 data from the Survey of Mental Health Organizations and General Hospital Mental Health Services. Data prior to 2000 on 30 and 180 readmissions are unavailable. However, the rate of any readmission has declined from 80 percent in 1980 to 75 percent in 1986 and 68 percent in 1997 according to data from SAMHSA and the National Institute of Mental Health at HHS. The number of resident patients has also declined. Assessment based on agency planning documents, GPRA reports, SAMHSA-wide performance measures document and draft measures for the performance partnership grant.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?
Answer: SMALL EXTENT
Question Weight: 25%

Explanation: The agency is meeting the standards of a Yes for having incentives and procedures to measure and achieve efficiencies. A Small Extent is given because the program has not demonstrated large gains over the prior year. The program cites an increase in state expenditures per block grant dollar of $8.35 in 1983 to $38.59 in 2001 as evidence of improved efficiency from the federal perspective. While significant, increased investments at the state level do not necessarily relate to the efficiency of federal operations. Measures of reduce psychiatric hospital readmissions will provide additional data on program level efficiency improvements in the future.

Evidence: The agency's efforts to transition to a performance partnership grant are intended to reduce requirements in the block grant through an increase reliance on reporting on outcomes. The new structure should enable the program to more efficiently achieve outcome goals in mental health treatment.

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?
Answer: NA
Question Weight: 0%

Explanation: Numerous Federal funding sources are available to support mental health treatment for adults with serious mental illness and children with serious emotional disturbance. State and local entities also invest resources in this area. However, the block grant is the only federal activity designed specifically to support state-wide services to all states in this area. No comparisons of the effectiveness of treatment services through Medicaid and treatment services supported by the block grant have been conducted.

Evidence: Evidence includes agency budget reports, GAO/GGD-98-137, SGR 1999, and agency documents.

Program ID: 10001061

Program Assessment Rating Tool (PART)

Program: Community Mental Health Services Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	88%	89%	25%	

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?** Answer: NO Question Weight: 25%

Explanation: The program has not yet had evaluations meeting the standard for this question that are at the national program level, rather than one or more partners, and focused on the program's impact, effectiveness or other measurement of performance. The program and the partners receive valuable information from state planning council reviews, but the reviews are not comprehensive evaluations with respect to this question. Similarly, state profiles provide valuable information on financing, staffing, service, information technology and other areas for managing the program, but are not independent evaluations. Research confirms the efficacy of mental health treatment more broadly. As noted in Section II, additional steps are also being taken to support evaluations in the future.

Evidence: The agency conducts reviews of state activities through on-site reviews, reviews of applications, and reviews of financial audit reports. Annual program reviews are also conducted by State Mental Health Planning Councils. However, GAO notes that the councils generally lack expertise in evaluation and reviews are not consistently accompanied by back-up information (GAO/GGD-98-137). The agency reports that since the GAO report these reviews have become more sophisticated. RAND has examined the formula and GAO has examined the federal involvement in this area overall, but neither have performed comprehensive evaluations of the program. The state technical reviews provide information on the states obligations and expenditures in accordance with the statute, service delivery by modality, quality improvement for clinical services and management, and opportunities for improvement and targeted technical assistance.

PART Performance Measurements

Program: Community Mental Health Services Block Grant

Agency: Department of Health and Human Services

Bureau: Substance Abuse and Mental Health Services Administration

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Measure: Rate of readmission to State psychiatric hospitals (a) within 30 days (b) within 180 days

Additional Information: Readmission is useful as an indicator of the desired outcome of developing a community-based system of care.

Year	Target	Actual	**Measure Term:** Long-term
2000		8.2/18.1	
2008	5/15.1		

Measure: Rate of consumers/family members reporting positively about outcomes for (a) adults and (b) children/adolescents.

Additional Information:

Year	Target	Actual	**Measure Term:** Long-term
2002		70/63	
2008	75/68		

Measure: Number of people served by state mental health systems.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
1992		3664471	
1998		3511858	
2002		4275862	
2005	4404138		

Measure: Number of SAMHSA-identified, evidence-based practices in each state and the percentage of service population coverage for each practice.

Additional Information: Implementation of these practices results in better quality mental health care for persons served in state public mental health systems and will also make care more cost efficient over time.

Year	Target	Actual	**Measure Term:** Annual
2003		Baseline	

PART Performance Measurements

Program: Community Mental Health Services Block Grant

Agency: Department of Health and Human Services

Bureau: Substance Abuse and Mental Health Services Administration

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Measure: Rate of readmission to State psychiatric hospitals (a) within 30 days (b) within 180 days

Additional Information: Readmission is useful as an indicator of the desired outcome of developing a community-based system of care.

Year	Target	Actual	**Measure Term:** Annual
2000		8.2/18.1	
2005	7.6/17		

Measure: Rate of consumers/family members reporting positively about outcomes for (a) adults and (b) children/adolescents.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2000		70/63	
2005	73/65		

Program Assessment Rating Tool (PART)

Program: Community Services Block Grant
Agency: Department of Health and Human Services
Bureau: Administration for Children and Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	13%	89%	0%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The program's purpose is to reduce poverty, revitalize low-income communities and empower low-income families and individuals to be self-sufficient. To accomplish this purpose, CSBG provides flexible core or foundational funding to over 1000 community-based organizations (Community Action Agencies, or CAAs) in almost every county in the nation to promote innovative, community-generated and location-specific actions to reduce the incidence and severity of poverty.

Evidence: Community Opportunities, Accountability, and Training and Educational Services Act of 1998 (Coats Human Services Reauthorization Act of 1998)--title II, Subtitle B--Community Services Block Grant Program (42 U.S.C. 9901 et seq); Community Services Block Grant Program Fact Sheet; and History, Purpose and Perspective Information Sheet.

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: Poverty in America remains a persistent and complex problem, often rooted in market or societal conditions, especially unemployment, inadequate housing, and a lack of educational opportunity.

Evidence: U.S. Census Bureau, OMB Poverty Thresholds for 2002, CSBG Act (42 U.S.C. 9902--Poverty Line) and CSBG Act (42 U.S.C. 9910--tripartite Boards).

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: The program is designed to empower communities to address local needs via the tripartite Board governance structure of CAAs. Consisting of three groups--public officials, members of the low-income community, and private community leaders--tripartite boards enable CAAs to allocate resources to complement and coordinate with other programs. No other program provides a stable dynamic platform for sustained community-based creativity and flexibility in addressing the multi-faceted problem of poverty.

Evidence: Draft CSBG Statistical Report FY 2001: Chart titled, "FY 2001 CSBG-Funded Local Agency Resources in 49 States, DC, and Puerto Rico (in millions of dollars)" and list of program funding sources. Also, CSBG Act (42 U.S.C. 9901--tripartite Boards)

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: NO Question Weight: 20%

Explanation: Current law does not require minimum performance standards of CAAs as a condition of continued funding. In very rare circumstances, States have designated CAAs as deficient and terminated funding to the entity, but only infrequently. As a result, CAAs are a largely static group unchallenged by competitive pressures for continous performance improvement.

Evidence: Economic Opportunity Act of 1964; 1981 CSBG Act; CSBG Act reauthorizations in 1984, 1986, 1990, 1994 and 1998.

Program ID: 10001055

Program Assessment Rating Tool (PART)

Program: Community Services Block Grant
Agency: Department of Health and Human Services
Bureau: Administration for Children and Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	13%	89%	0%	

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: Resource targeting is accomplished by needs assessments. Case management intake processes ensure that intended beneficaries are reached and unintended subsidies are avoided. All of the activities of CSBG-funded community agencies are focused on low-income individuals.

Evidence: Community Services Block Grant Program (42 U.S.C. 9902 - Definitions..Poverty Line) ; (42 U.S.C. 9908 - Application and Plan); CSBG Statistical Report; sample Intake Form; and sample Needs Assessment Instrument.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: NO Question Weight: 12%

Explanation: A new measure is under development, and may be included in the FY 2005 GPRA Plan. While this measure represents an encouraging step toward a singular national performance indicator, there remain unresolved technical concerns with the measure. Most importantly, the developmental measure aggregates some national performance indicators which track absolute numbers and do not measure relative success.

Evidence: Information Memorandum 49, ROMA Guide: Family Agency Community Outcomes; proposed 2005 GPRA measures; and, National Performance Indicators (draft).

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: NO Question Weight: 12%

Explanation: Baseline data for newly developed long-term targets are being collected.

Evidence: Draft U.S. HHS FY 2005 OMB Request for Information and GPRA Performance Plan - Administration for Children and Families - Community Services Block Grant Section.

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: NO Question Weight: 12%

Explanation: A new measure is under development, and may be included in the FY 2005 GPRA Plan. States and local agencies report outcomes for six long-term national goals that reflect the needs of particular service areas. While various outcomes for each goal are reported by States and local agencies annually, there is no set of national outcome measures for which all states and local agencies must report.

Evidence: Annual Report of Performance Outcomes from the CSBG Program and Proposed 2005 GPRA measures.

2.4 Does the program have baselines and ambitious targets for its annual measures? Answer: NO Question Weight: 12%

Explanation: While targets have been established for existing CSBG GPRA performance measures, actual performance exceeds even future targets by such an extent that they are not ambitious.

Evidence: U.S. HHS FY 2004 OMB Request for Information and GPRA Performance Plan-ACF - Community Services Block Grant Section and Proposed 2005 GPRA measures.

Program ID: 10001055

Program: Community Services Block Grant
Agency: Department of Health and Human Services
Bureau: Administration for Children and Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	13%	89%	0%	

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: NO Question Weight: 12%

Explanation: New long-term and annual measures are under development. While various outcomes for each goal are reported by States and local agencies annually, there is no set of national outcome measures for which all states and local agencies must report. However, CSBG performance measurement strategies (Results Oriented Management and Accountability, or ROMA) were initiated in 1994, and became mandatory on October 1, 2001. All States met that statutorily required deadline, and the first report of CSBG outcomes was released in early 2003. ROMA was developed collaboratively among Federal, State and local agencies over a nine year period.

Evidence: Annual Report of Performance Outcomes from the CSBG Program, Regional Meeting Summary: ROMA Implementation by 2003, Information Memorandum 49 (specifies the requirements for undertaking performance measurement and reporting) and proposed FY2004 specifications for CSBG reauthorization.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: NO Question Weight: 12%

Explanation: There are currently no independent evaluations for CSBG. No funds are appropriated for this purpose. However, data is collected annually from States on both program inputs (resources, services) and outputs (impact on beneficiaries and communities). States may use this information to assess local agency effectiveness.

Evidence: Program Implementation Assessment Instrument; CSBG Act (42 U.S.C. 9913 - Training, Technical Assistance and Other Activities); and CSBG Act (42 U.S.C. 9914 - Monitoring of Eligible Entities).

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: CSBG annual budget requests, as do those of most all ACF programs, include a budget linkage table that displays outputs and outcomes associated with the aggregate program budget authority. This table does not provide a presentation that makes clear the impact of funding, policy, or legislative decisions on expected performance nor does it explain why the requested performance/resource mix is appropriate.

Evidence: CSBG Act (42 U.S.C. 9917 - Accountability and Reporting Requirements).

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: The CSBG program has been engaged in a nine year initiative to use performance based management as a tool for strategic program planning, programming and accountability. New national measures are currently being developed for CAAs. OCS is undergoing a restructuring process to better address the needs of all OCS programs. Finally, the reauthorization proposal will strengthen outcome reporting.

Evidence: Information Memorandum 49; Regional Meeting Summary: ROMA Implementation by 2003; CSBG National Performance Indicators (draft); and OCS Restructuring Plan (to be published in the Federal Register).

Program ID: 10001055

Program Assessment Rating Tool (PART)

Program: Community Services Block Grant
Agency: Department of Health and Human Services
Bureau: Administration for Children and Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	13%	89%	0%	

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 11%

Explanation: The CSBG program utilizes annual program output and performance information from States and local CSBG-funded community agencies to identify training and technical assistance needs. A number of States now use performance-based management and outcome information to guide State and local CSBG strategic planning, programming, evaluation and reporting.

Evidence: CSBG Statistical Report; Annual Report of Performance Outcomes from the CSBG Program and OCS Restructuring Plan

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 11%

Explanation: The Director of OCS and other ACF managers are held accountable for their performance through their Employee Performance contract for cost, schedule, and performance results, as required by GPRA. CAA Executive Directors are held accountable by tripartite Boards for cost, schedule, and achieving program outcomes through annual performance appraisals.

Evidence: CSBG Act (42 U.S.C. 9913 - T/A); CSBG Act (42 U.S.C. 9914 - Monitoring) ; CSBG Act (U.S.C. 9915 - Corrective Action); OCS Director's performance plan; Mid-Iowa Comm. Action's (MICA) Performance Accountability Plan; MICA's Qtrly. Personal Development Plan; State/local Audits; and CAA Executive Handbook pgs. 96-98.

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: YES Question Weight: 11%

Explanation: CSBG funds are allocated to States by formula. States must "pass through" at least 90% of their allocation to eligible local entities based on distribution formulae based on census or other demographic data concerning poverty. With few exceptions, funds are allocated to local eligible entities as soon as they are made available, and in accordance with a State-approved program plan.

Evidence: Financial Status Reports (SF 269A); Grant Award Letters; disbursement summaries; FY 2001 Statistical Report Highlights; Payment Center "draw down" data from 1993 to 2002; Subgrantee (Sandhills CAP) contract with the State of NC and State monitoring review form; Subgrantee Project Review Report; A-133 Compliance Supplement for CSBG (CFDA 93.569); & State/local Audits.

3.4 **Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: NO Question Weight: 11%

Explanation: While the program does have procedures in place to achieve efficiencies and cost effectiveness, there are no procedures in place by which to measure such efficiencies at the program level. For example, competitive sourcing and IT improvements are used to improve efficiency and cost effectiveness in program execution. OCS plans to include a CSBG financial resource leveraging efficiency measure to the FY 2005 GPRA Plan.

Evidence: FY 2004 OMB Request for Info. & GPRA Perf. Plan-ACF - CSBG Section; CT's IT sharing plan; CSBG Act (42 U.S.C. 9901-Sec 672(2)(E)); "MMDB" Team and report at: www.roma1.org/documents/mmdb/decision-makers-guide.pdf; History, Purpose & Perspective Info. Sheet; ACF Competitive Sourcing Plan; and OCS MIS Plan.

Program ID: 10001055

Program Assessment Rating Tool (PART)

Program: Community Services Block Grant
Agency: Department of Health and Human Services
Bureau: Administration for Children and Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	13%	89%	0%	Results Not Demonstrated

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 11%

Explanation: CSBG work is unique by virtue of its extensive Federal, State and local coordination and collaboration in response to multiple needs of low-income households. For example, some 37% of Head Start classes and more than 40% of LIHEAP programs are managed by CAAs. These and other coordinated efforts secure and maintain employment, education, income management, housing, emergency services, nutrition, health and other services that respond to the needs of low-income individuals and families. Without such partnerships, community action would not be able to achieve and sustain favorable family, community and agency outcomes.

Evidence: Child Support Memorandum of Understanding (MOU); Head Start (2 MOU's); IRS (2 MOU's); HUD Lead Hazard Control (MOU); DOL Workforce Investment Act Partnership; CSBG Act (42 U.S.C. 9908 - Application and Plan -Assurances 5&6); and, FY 2000 CSBG Statistical Report pages 49 through 68.

3.6 Does the program use strong financial management practices? Answer: YES Question Weight: 11%

Explanation: ACF has received a clean audit opinion from FY 1999 to 2002 (the last stand alone audit conducted), identifying no material internal control weaknesses. However, State agencies have primary responsibility for insuring the integrity and strength of financial management of funds by local CSBG grantees. States practices include: conducting periodic on-site review of financial management practices and recordkeeping/reporting practices of local agencies as part of routine program monitoring; receipt and review of interim and final expenditure reports submitted by local agencies; and periodic independent financial audits of local agencies, for not only the CSBG program but also for other programs administered by local CAAs. Finally, because local agencies have unique vulnerabilities, HHS has utilized its discretionary grant authority to provide special assistance to States and local agencies focused on continuous monitoring and improvement of financial management.

Evidence: CSBG T/TA Program Announcements; Program Implementation Assessments (PIA); CSBG Act: (42 U.S.C. 9913 - T/TA); (42 U.S.C. 9914 - Monitoring); (42 U.S.C. 9915 - Corrective Action); (42 U.S.C. 9916 - Fiscal Controls); CAA Executives Handbook; State/local Audits; ACF audits; Federal Financial Management Improvement Act; and, ACF Audit Workgroup Questionnaire.

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 11%

Explanation: Federal, State and local CSBG authorities utilize a variety of mechanisms to identify and correct management deficiencies, including: annual on-site monitoring of local programs that focuses on program and management requirements of the law; national leadership training and inservice programs for local managers; intensive on-site remediation of significant deficiencies within at-risk agencies; and the ongoing effort to establish linkages between management protocols and program performance measurement and reporting.

Evidence: CSBG T/TA Program Announcements; Program Implementation Assessments; CSBG Act: (42 U.S.C. 9913 - T/TA); (42 U.S.C. 9914 - Monitoring); (42 U.S.C. 9915 - Corrective Action); (42 U.S.C. 9916 - Fiscal Controls) and CSBG Report to Congress.

Program Assessment Rating Tool (PART)

Program: Community Services Block Grant
Agency: Department of Health and Human Services
Bureau: Administration for Children and Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	13%	89%	0%	Results Not Demonstrated

3.BF1 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: YES Question Weight: 11%

Explanation: Oversight is achieved through a variety of Federal and State mechanisms, including application review, annual on-site monitoring, fiscal reports and audits, performance measurement and reporting, and techical assistance.

Evidence: Program Assessments (PIA); CSBG Act: (42 U.S.C. 9908 - State Plan, 9913 - T/TA, 9914 - Monitoring, 9915 - Corrective Action, 9916 - Fiscal Controls); ACF Audit Questionnaire; subgrantee Project Review Report; State Internal Review Form; State Grantee Review & Assmt. Report; and, State/local audits.

3.BF2 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: YES Question Weight: 11%

Explanation: As required by the CSBG Reauthorization Act of 1998, all States submitted ROMA-generated performance data for Fiscal Year 2001. A report of this data has been published and has been made available to the public both in print and electronically.

Evidence: Annual Report of Performance Outcomes from the CSBG Program and CSBG Statistical Report.

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: NO Question Weight: 25%

Explanation: As noted in 2.1, these measures are under development, and as such, there is not yet any progress toward the goals. CSBG has successfully installed a universal system for tracking and reporting performance outcomes at the individual, local agency, State, and Federal levels. The program is changing its GPRA measures to be more outcome oriented and the Administration's proposed reauthorization language calls for more accountability at the grantee level.

Evidence: Information Memorandum 49; Annual Report of Performance Outcomes from the CSBG Program; U.S. HHS FY 2004 OMB Request for Information and GPRA Performance Plan -ACF - CSBG Section; proposed FY 2004 Specifications for CSBG reauthorization; and, proposed FY 2005 GPRA measures.

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: NO Question Weight: 25%

Explanation: As noted in 2.3, these measures are under development, and as such, there is not yet any progress toward the goals.

Evidence: Draft HHS FY 2005 OMB Request for Information & GPRA Performance Plan - ACF - CSBG Sec.; ROMA Guide: Family Agency Comm. Outcomes; and, FY 2004 Performance Plan/FY 2002 Performance Report (GPRA).

4.3 **Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** Answer: NO Question Weight: 25%

Explanation: As noted in 3.4, while the program does have procedures in place to achieve efficiencies and cost effectiveness, there are no measures in place by which to capture such efficiency gains.

Evidence: Draft U.S. HHS FY 2005 OMB Request for Information and GPRA Performance Plan - Administration for Children and Families - CSBG Section.

Program Assessment Rating Tool (PART)

Program: Community Services Block Grant
Agency: Department of Health and Human Services
Bureau: Administration for Children and Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	13%	89%	0%	

4.4 **Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?** Answer: NA Question Weight: 0%

Explanation: CSBG is the only program that has the statutory mission and flexibility to accomplish multiple tasks through varied strategies and partnerships. No other program corresponds to CSBG in terms of its broad anti-poverty mission and goals. CSBG effectiveness is measured not only by the services directly provided, but more importantly, by revitalizing low-income communities.

Evidence:

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?** Answer: NO Question Weight: 25%

Explanation: There are currently no independent evaluations for CSBG. No funds are appropriated for this purpose. However, an HHS grant supports an annual assessment and reporting of CSBG performance outcomes.

Evidence: Annual Report of Performance Outcomes from the CSBG Program.

Program ID: 10001055

PART Performance Measurements

Program: Community Services Block Grant
Agency: Department of Health and Human Services
Bureau: Administration for Children and Families

Measure: Number of connditions of poverty reduced.

Additional Information:

Year	Target	Actual

Measure Term: Long-term

Research & Development Programs

Name of Program: Data Collection and Dissemination

Healthcare Cost & Utilization Project (HCUP), Medical Expenditure Panel Survey (MEPS), Consumer Assessments of Health Plans (CAHPS)

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The Public Health Service Act (PHS) states the purpose of AHRQ "is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services through the establishment of scientific research and the promotion of improvements in clinical and health system practices." Such activities include: 1) "conduct[ing] a survey to collect data on a nationally representative sample of the population on the cost, use and, ... quality of healthcare, including the types of health care services Americans use, their access to health care services, frequency of use, how much is paid for the services used, the source of those payments, the types and costs of private health insurance, access, satisfaction, and quality of care..." (MEPS); 2) developing tools to collect data "the costs and utilization of, and access to health care..." (HCUP); and 3) "develop[ing] survey tools for the purpose of measuring participant and beneficiary assessments of their health care..." (CAHPS).	Reauthorized 2000-2005 (P.L. 106-129) under the Healthcare Research and Quality Act, which amends Title IX of the Public Health Service Act (http://www.ahrq.gov/hrqa99.pdf).	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program address a specific interest, problem or need?*	Yes	The availability of national, representative data on the status of the health care delivery system and its costs and utilization are limited. Health care is both a national and local issue. As a result of HCUP, CAHPS, and MEPS data collection and dissemination tools researchers, institutions, and policy officials have ready access to a wide breath of national and state level data to accurately reflect the status of the health care system and expenditures for accessing/providing care in the system.	1) http://www.ahrq.gov/data/hcup/ 2) http://www.meps.ahrq.gov/ 3) http://www.ahrq.gov/qual/cahps/	17%	0.2
3	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	Some of the data collected/disseminated for MEPS and HCUP are similar to that of data provided by the National Center for Health Statistics funded by the CDC. However, the MEPS sample sizes and HCUP databases are larger and more detailed. More complex and representative questions from researchers/policy officials may be answered using AHRQ's tools. AHRQ's tools are used to standardize information so that it may be compared across states and health care delivery systems. The MEPS Health Insurance Component Survey provides data regarding establishments' expenditures; this information is not collected elsewhere across government. MEPS also collects longitudinal data from households, information about linkages between employment and insurance, and medical expenditure and utilization data in an event-by-event manner. NCHS conducts snapshot household and person-based data.	HCUP's standardized databases include nationwide inpatient samples and 29 state inpatient databases, 15 state ambulatory surgery databases, 7 pilot emergency department database, and the Kids' inpatient database. MEPS survey instruments are designed to collect national data on medical expenditures for more than 9,000 households; medical provider expenses for more than 23,000 physicians, 9,000 pharmacies, and 11,000 hospitals. NCHS documents the health status of the population and of important subgroups, describes our experiences with the health care system, monitors trends in health status and health care delivery, identifies health problems, and supports biomedical and health services research.	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program optimally designed to address the interest, problem or need?*	Yes	These instruments collect and disseminate large amounts of data that are more nationally representative than other tools. As a result, researchers/policy officials can use these data to capture uncommon conditions/procedures and population subgroups. These tools are designed to fill gaps in the availability of private sector, nationally collected and disseminated data.		17%	0.2
5 (RD 1)	*Does the program effectively articulate potential public benefits?*	No	These programs do not effectively articulate potential public benefits. For the most part, the data from these tools are available for discrete groups (researchers/policy officials/Medicare beneficiaries/specific institutions) and not the general public. AHRQ has developed fact sheets for some of these tools, which indicate the inclusion of these data in Federal Employees Health Benefits Program materials (CAHPS), materials provided to Medicare beneficiaries/specific institutions (CAHPS), and papers provided to policy officials to make decisions on program changes (MEPS). These vehicles tend to provide access to but not necessarily use by these groups. These data are not used in a wide-scale way by the general public, likely because of the lack of a clear and effective explanation of the public benefit.	1) HCUP/Quality Indicators Fact Sheet (http://www.qualityindicators.ahrq.gov/data/hcup/prevqifact.htm). 2) CAHPS Fact Sheet (http://www.ahrq.gov/qual/cahpfact.htm). 3) Advantage of MEPS (http://www.ahrq.gov/data/mepsadva.htm).	17%	0.0
6 (RD 2)	*If an industry-related problem, can the program explain how the market fails to motivate private investment?*	Yes	In the mid-1990s, attempts to encourage the private sector to build multi-state databases were not successful in large part due to lack of profit associated with such a project, and because of data confidentiality issues. Private organizations have few incentives to develop tools for assessment of health plans other than the type they manage (HMO vs. fee-for-service). MEPS has taken on the role to fill the gap left by market failure and makes the data available to the public.		17%	0.2
Total Section Score					**100%**	**83%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning (Yes,No, N/A)						
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	OMB and AHRQ recently developed ambitious long-term outcome goals that link to the mission of the program. In some cases baseline data are to be determined, but AHRQ believes these data can be collected.	AHRQ's newly developed long-term outcome goals are: 1) Data from the MEPS survey will be available within 12 months of completion of the survey by 2008 and 2) At least 5 organizations (e.g., federal organizations, state organizations, private associations, health plans, employers, employer groups) will use HCUP databases, products, or tools, to improve statewide health care quality for their constituencies by 10% as defined by the AHRQ Quality Indicators by 2010.	11%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	AHRQ's annual GPRA plan includes annual goals, many of which are process-oriented. OMB and AHRQ recently developed discrete, quantifiable, and measurable annual performance goals that demonstrate progress toward achieving the long-term goals.	AHRQ's newly developed annual goals are: 1) “Point-in-time” data from the Household Survey and Insurance Component tables will be available within 12 months of collection, 2) Data from the Household Survey reflecting expenditures will be available within 12 months from the end of Medical Provider Component data collection, and 3) Develop implementation strategy for long-term goal related to HCUP databases, products, or tools to improve health care quality for organizations' constituencies.	11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	The MEPS contracts for data collection and production specify the same data release expectations as their performance goals. With some contracts these measures are a part of their performance based contract plans. HCUP requires contractors to commit to tasks contributing to performance goals and file reports by phone weekly, and written monthly and annual reports. CAHPS work plans include statements of tasks and sub-tasks required to achieve specific goals, identification of staff with responsibility for that activity, and dates by which tasks and sub-tasks must be completed. Project Officers also use these documents to measure progress toward completion of activities as they perform their annual site visits with each grantee. If progress is insufficient, the cooperative agreement may be terminated.	1) Work plan tasks and subtasks. 2) Grantee progress reports. 3) Grantee financial status reports.	11%	0.1
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	There are few programs with similar goals and objectives. AHRQ, as part of its MEPS activities, is a member of the Interagency Committee on Employment-Related health insurance surveys which considers and recommends collaborative efforts that will improve employment-related data collection activities. AHRQ also collaborates with sister agencies across HHS on HCUP-related items to provide evidence on cost and quality of particular treatments. The CAHPS team also collaborates with non-governmental agencies. Packard Foundation had funded a questionnaire to assess care given to children with special health care needs; CAHPS was also working on a similar questionnaire. To avoid duplication, AHRQ partnered with the Packard Foundation team and the National Committee for Quality Assurance to develop the Child and Adolescent Healthcare Measurement Initiative, a single instrument.		11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	MEPS surveys began in 1977. In 1987 a National Medical Expenditure Survey Planning Contract and several IG evaluations reviewed components of the MEPS portfolio. The evaluations found that there were significant time lags between the survey and the time data were released for public use, as well as inefficiencies in program design. Because of these evaluations, AHRQ conducted an extensive management and program restructuring of MEPS that improved the structure of the survey as well as the time it takes to release the data. Other evaluations of the new MEPS and HCUP also occur.	1) 1987 Report on NMES Planning Contract. 2) Office of the Inspector General: Evaluation of the 1987 NMES. 3) HHS Evaluations of the Design of the 1987 NMES. 4) Reports on components of the 1996 MEPS. 5) Evaluation of HCUPnet and Central Distributor 2002.	11%	0.1
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	AHRQ's OMB budget justification and Congressional justification display the AHRQ budget. However, when AHRQ submits its budget request to the Department for review, the annual targets are adjusted according to the funding level requested and/or the final funding level provided by the Department. Budget requests and funding level decisions are not made based on achieving the established long-term and annual performance goals. In addition, AHRQ does not have in place a model/mechanism that allows it to determine per unit cost of service to help in adjusting its budget or program targets accordingly.	1) OMB Budget Justification submitted each Fall. 2) Congressional Justification submitted each February with the President's Budget.	11%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	AHRQ has acknowledged the multiple difficulties of tracking budgetary expenditures along with tying these expenditures to actual program performance. AHRQ plans, using budgeted FY 2003 resources, to begin to deploy a reporting module (phase I) to the activity areas allowing them to view and track their own budgets. Phase II will allow the activity areas to interconnect appropriate areas of the Agency's planning system with the budget system through a set of common fields, and finally, the GPRA program goals. The ultimate goal of this project will be targeted integration of the existing Agency planning database with the budget database system, allowing Agency leadership to easily identify, and flag for action those program areas that are not meeting their GPRA goals.		11%	0.1
8 (RD 1)	*Is evaluation of the program's continuing relevance to mission, fields of science, and other "customer" needs conducted on a regular basis?*	Yes	In the mid-1990s, attempts to encourage the private sector to build multi-state databases were not successful and lead to internal reviews of program/activity mission and relevance. MEPS was overhauled and regular evaluations of these programs/activities are being conducted.		11%	0.1
9 (RD 2)	*Has the program identified clear priorities?*	Yes	Overall, the priority for these activities is to collect and disseminate timely data on cost and utilization of health care services, as well as to make available feedback on customers' perception of the care they received and their health plans. Furthermore, through communication with users, workshops, meetings, and planned customer surveys MEPS assesses/will assess community needs. HCUP routinely solicits outside feedback and guidance through the annual meeting with the 29 HCUP partner states and stakeholder meetings. AHRQ program staff also review performance goals on an annual basis and prioritize these goals in accordance with AHRQ's mission. The AHRQ reauthorization also states the purpose of the agency and thus the intent of these activities.	1) Reauthorized 2000-2005 (P.L. 106-129) under the Healthcare Research and Quality Act. 2) http://www.ahrq.gov/hrqa99a.htm. 3) Congressional Justification. 4) Annual GPRA Plan.	11%	0.1

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Total Section Score				**100%**	**89%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section III: Program Management (Yes,No, N/A)						
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	AHRQ regularly collects data on the annual performance goals established in the GPRA plan and grantees and internal efforts to meet these goals. CAHPS work plans include statement of tasks and sub-tasks required to achieve specific goals, identification of staff with responsibility for that activity, and dates by which tasks and sub-tasks must be completed. Project Officers also use these documents to measure progress toward completion of activities as they perform their annual site visits with each grantee. If progress is insufficient, the cooperative agreement may be terminated. Similar mechanisms are in place for the other programs.	1) Work plan tasks and subtasks. 2) Grantee progress reports. 3) Grantee financial status reports.	10%	0.1
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The Agency's strategic plan guides the overall management of the agency. Each Office and Center has an individual strategic plan and annual operating plan. Cost, schedule and performance are part of the performance plans of the AHRQ management, including Division, Center, and Agency Directors. The annual operating plan identifies those things that contribute to AHRQ achieving its performance goals and internal management goals. These factors are incorporated into each employee's annual performance plan/review. At the end of each year, the Office and Center Directors review accomplishments in relation to the annual operating plans in preparation for drafting the next year's plans. The results of these reviews contribute significantly to Office and Center performance reports. Some managers performance plans also take into consideration their staffs performance in managing program operation. In addition, contracts are performance-based.	Program managers' performance contract.	10%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	All appropriated funds are obligated in accordance with the annual operating plans, formulated for obligation and outlay on a quarterly basis.	1) Estimated obligations by quarter in apportionments for FYs 1999-2002. 2) Actual obligations by quarter for FYs 1999-2002.	10%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	The programs' operating plans do not include efficiency and cost effectiveness measures and targets that address such things as per unit cost or some other measures directly linked to the activities of the program.	2002 Operations Plan Goals.	10%	0.0
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	Although AHRQ is able to provide the cost of unit service for the MEPS activities, this PART also addresses HCUP and CAHPS. AHRQ does not have in place a model/mechanism that allows it to determine per unit cost of service for CAHPS and HCUP. Therefore, AHRQ does not adjust its budget or program targets accordingly. Furthermore, although AHRQ's OMB budget justification and Congressional justification display the AHRQ budget, when AHRQ submits its budget request to the Department for review, the annual targets are adjusted according to the funding level requested and/or the final funding level provided by the Department. Budget requests and funding level decisions are not made based on achieving the established long-term and annual performance goals.		10%	0.0
6	*Does the program use strong financial management practices?*	NA	Because the Department prepares audited financial statements for its largest components only, AHRQ's financial statements are not audited. In 2002, AHRQ engaged Clifton Gunderson LLP for technical support consultation and analysis for certain financial management practices.		0%	
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	Programs are adopting performance-based contracts which require superior performance by the contractor to receive the full project fee. Other contracts are awarded on a competitive basis or sole sourced to capable entities with proven results.		10%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
8 (RD 1)	*Does the program allocate funds through a competitive, merit-based process, or, if not, does it justify funding methods and document how quality is maintained?*	Yes	AHRQ announces research grant opportunities through program announcements (PA) and requests for applications (RFA). Contract opportunities are announced through a similar process. Grant applications are reviewed for scientific and technical merit by a peer review group with appropriate expertise. Funding decisions are based on the quality of the proposed project, availability of funds, and program balance among research areas. Contracts are awarded using a similar process.		10%	0.1
9 (RD 2)	*Does competition encourage the participation of new/first-time performers through a fair and open application process?*	Yes	HHS' policies create a fair and open competition including making project documents and products available for review by new bidders. Also, the PAs and RFAs encourage the development of new ideas and research questions that will benefit the field.	1) Requests for Proposals. 2) Requests for Information. 3) Statements of Work.	10%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
10 (RD 3)	*Does the program adequately define appropriate termination points and other decision points?*	Yes	Major tasks and expansion plans have interim steps that allow for review and evaluation to permit appropriate termination or progression. Contracts contain option years so that the program can extend its activities for defined periods of time. Each year, as part of the AHRQ work plan development, activities are assessed for their continuing utility.	Operation Plan.	10%	0.1
11 (RD 4)	*If the program includes technology development or construction or operation of a facility, does the program clearly define deliverables and required capability/performance characteristics and appropriate, credible cost and schedule goals?*	Yes	HCUP and MEPS involve certain forms of technology development. HCUP developed a series of interactive databases and MEPS uses a computerized data collection process. Contracts are performance-based. Project Officers also use these documents to measure progress toward completion of activities as they perform their annual site visits with each grantee. If progress is judged as insufficient, the cooperative agreement may be terminated. Similar mechanisms are in place for the other programs.	Contractor Progress Reports.	10%	0.1
Total Section Score					**100%**	**80%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Small Extent	AHRQ has contributed to the overall availability of longitudinal national and state level data. AHRQ has already begun focusing its efforts toward improving the availability of timely data through the redesign of its MEPS program, as a result of findings about deficiencies in the program. More outcome-oriented goals need to be developed regarding HCUP and CAHPS activities.	The time it takes to have MEPS data available for use and analysis have improved from 1997 to date. AHRQ continues to strive for improved performance overtime.	25%	0.1

Long-Term Goal I:	Data from the MEPS survey will be available within 12 months of completion of the survey.
Target:	12 months after completion of the survey by 2008.
Actual Progress achieved toward goal:	19-27 months in 1997; 12-19 months in 2001.
Long-Term Goal II:	At least 5 organizations (e.g., federal organizations, state organizations, private associations, health plans, employers, employer groups) will use HCUP databases, products, or tools, to improve statewide health care quality for their constituencies by 10% as defined by the AHRQ Quality Indicators.

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Target:	5 organizations will improve health care quality by 10 percent by 2010.				
	Actual Progress achieved toward goal:	To be determined.				
	Long-Term Goal III:					
	Target:					
	Actual Progress achieved toward goal:					
2	*Does the program (including program partners) achieve its annual performance goals?*	Small Extent	AHRQ has maintained the timeframe of 12 months to have point-in-time data available. AHRQ has also improved the time between completing data collection efforts to data dissemination. More annual goals need to be developed for HCUP and CAHPS activities.	The time it takes to have MEPS point-in-time data available for use and analysis has been maintained at 12 months. AHRQ continues to strive for improved performance overtime for Household Survey data.	25%	0.1
	Key Goal I.A: **Linked to L-T Goal I**	"Point-in-time" data from the household survey and Insurance Component tables will be available within 12 months of collection.				
	Performance Target:	More than one month time reduction per year.				
	Actual Performance:	19 months after completion of the survey in 1997; 12 months after completion of the survey in 2001.				
	Key Goal I.B: **Linked to L-T Goal I**	Data from Household Survey reflecting expenditures will be available within 12 months from the end of Medical Provider Component data collection.				
	Performance Target:	More than two months time reduction per year.				
	Actual Performance:	19 months after completion of the survey in 2001; 27 months after the completion of the survey in 1997.				
	Key Goal II: **Linked to L-T Goal II**	Develop implementation strategy for long-term goal related to HCUP databases, products, or tools to improve health care quality for organizations' constituencies.				
	Performance Target:	Complete during FY 2003.				
	Actual Performance:	To be determined at the end of FY 2003.				
	Key Goal III: **Linked to L-T Goal III**					
	Performance Target:					
	Actual Performance:					
		Footnote: Performance targets should reference the performance baseline and years, e.g. achieve a 5% increase over base of *X* in 2000.				
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Yes	The average cost of these research collection and dissemination tools has decreased as AHRQ has realized cost efficiencies.	HCUP average costs of database development is $43,500; the estimate projects $46,000. MEPS costs range from $3,300 per case for household data to $9,351 for medical provider/pharmacies data.	25%	0.3
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	NA			0%	

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Yes	The HCUP evaluation of quality and how representative the National Inpatient database (1995-2000 data) indicated that HCUP is effective in both areas. An evaluation of HCUPnet and its Central Distributor released in 2002 also drew the same conclusions. The series of MEPS evaluations found that the program needed to be redesigned and thus a massive reform effort was conducted. A customer satisfaction survey is currently undergoing final signoff.		25%	0.3
6 (RD 1)	*If the program includes construction of a facility, were program goals achieved within budgeted costs and established schedules?*	NA			0%	
Total Section Score					**100%**	**67%**

Program Assessment Rating Tool (PART)

Program: Developmental Disabilities Grant Programs
Agency: Department of Health and Human Services
Bureau: Administration for Developmental Disabilities
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	75%	100%	25%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The Administration of Developmental Disabilities' (ADD) purpose is "to assure that individuals with developmental disabilities and their families participate in the design of and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life, through culturally competent programs." Included in this review are three grant pograms: (1) State Councils on Developmental Disabilities (SCDDs) to help communities create systems of supports and services for individuals with developmental disabilities; (2) Protection and Advocacy (P&A) systems to protect individuals with developmental disabilities from abuse, neglect, and violation of rights; and (3) University Centers for Excellence in Developmental Disabilities Education, Research, and Service (UCEDDs) to provide education, training, technical assistance, public information, and research.

Evidence: The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the Act), Sec. 101(b).

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: ADD's grantees address the problems of approximately four million individuals with developmental disabilities in the United States, many of whom need long-term if not lifetime services and supports to successfully and safely live in their communities. Grantees assist states and local communities in examining service systems, pursuing individual and systemic advocacy efforts, and coordinating the resources of universities to enhance community living for individuals with developmental disabilities in such areas as education, employment, housing, and health care.

Evidence: Almost every State has lists of eligible individuals waiting for supports to remain in or return to their communities. ADD tracks measures directly or indirectly related to assisting individuals with developmental disabilities access services and opportunities in community settings. Through its grantees and national data surveys ADD has learned: in 2002, there were 254,762 individuals with developmental disabilities on various waiting lists for housing or other community-based services (SCDD Program Performance Report (PPR)); in 2000, 672,994 adults with developmental disabilities had parents 60 years or older as their primary caregivers (Braddock, David, editor Disability at the Dawn of the 21st Century and the State of the States, 2002); 88 percent of individuals with developmental disabilities live with their parents or in their own households.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: Although there are other entities that serve individuals with developmental disabilities, ADD is the only Federal effort that systematically assesses the state of services to individuals with developmental disabilities. All grantee applications require strategic plans. For example, SCDDs are required to submit State Plans that include a comprehensive review and analysis of availability of services, identifying unmet needs and opportunities for collaboration with State, local and private entities. Grantees provide technical assistance (TA) and direct support, and collaborate to expand, create and improve services. ADD and its grantees strive to provide services that are not redundant or duplicative, but rather fill service gaps. Federal monitoring and legal oversight provided by ADD ensures program accountability and implementation of the Act.

Evidence: The Act specifies planning and reporting requirements for SCDDs (Sec 124 (c)(3)); P&As (Sec. 143); and UCEDDs (Sec. 153).

Program Assessment Rating Tool (PART)

Program: Developmental Disabilities Grant Programs
Agency: Department of Health and Human Services
Bureau: Administration for Developmental Disabilities
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	75%	100%	25%	

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: ADD's grantees have flexibility in the programs they administer to ensure that programs remain responsive to needs of consumers in a particular State. SCDDs, P&As, and UCEDDs all have advisory or governing boards comprised mostly of consumers who identify, on an on-going basis, needs and problems and resolve them in an efficient and effective manner. This process includes verification through collection of consumer satisfaction surveys and goal assessments. ADD monitors grantees on an on-going basis, and when problems are identified they are resolved through corrective action plans and TA. The Act also includes a provision to protect funds from supplantation or substitution.

Evidence: In 2002 approximately 3,235 individuals served on governing and advisory bodies to components of the DD program. Of these 1,736 were individuals who had disabilities. The Act includes requirements for governing bodies, the assessment of goals and objectives, and that funds be used to supplement, not supplant non-Federal funds (Sections 124, 125, 144, 154).

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: The resources and activities of ADD's programs are targeted toward individuals with substantial life-long disabilities that originated before they reached the age of 22. ADD's grantees identify service gaps and address systemic issues that impact individuals with substantial disabilities. Although not measured, it is possible that sponsored activities could benefit individuals with substantial disabilities who are not considered to be individuals with developmental disabilities. Grantees are required to report annually on the characteristics of the individuals they serve and the activities provided.

Evidence: 'Developmental disability' is defined in Sec. 102(8) of the Act. References for composition of SCDDs (Sec. 125(b)), P&A boards and advisory councils (Sec. 144), and UCEDDs advisory councils (Sec. 154(a)(3)(E)). ADD grantee Program Performance Reports.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation: ADD has meaningful long-term, outcome-based goals for FY 2003 through FY 2007. Since 1998 ADD has tracked performance measures under GPRA reporting requirements; however, some measures were based on outputs instead of outcomes. The new measures directly reflect the program's purpose that individuals with developmental disabilities and family members: (1) have access to community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, independence, and inclusion in all facets of community life, and (2) participate in the design of services.

Evidence: Administration on Children and Families FY 2004 Performance Plan. Revised measures will be reflected in the FY 2005 Performance Plan.

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation: ADD and its grantees developed ambitious and achievable targets that impact an increased number of individuals with developmental disabilities relative to the national population (ambitious), while being based on data-driven strategic planning (achievable). The timeframes coincide with the next scheduled reauthorization of the legislation.

Evidence: Administration on Children and Families FY 2004 Performance Plan. Targets will be reflected in the FY 2005 Performance Plan.

Program Assessment Rating Tool (PART)

Program: Developmental Disabilities Grant Programs
Agency: Department of Health and Human Services
Bureau: Administration for Developmental Disabilities
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	75%	100%	25%	

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 12%

Explanation: ADD developed seven annual performance measures to support its three long-term goals. ADD is working to develop a meaningful efficiency measure.

Evidence: Administration on Children and Families FY 2004 Performance Plan. Revised measures will be reflected in the FY 2005 Performance Plan.

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: Baselines are generated from the grantees annual performance reports. Annual measures are consistent with targets for the long-term measures and are developed through the same strategic planning process.

Evidence: Administration on Children and Families FY 2004 Performance Plan. Revised measures will be reflected in the FY 2005 Performance Plan.

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: ADD developed long-term and annual performance measures. ADD's grantees commit to the performance goals and measures through required planning documents and annual reporting of progress on the performance measures. The planning documents are monitored to ensure the commitment of grantees and subgrantees to ADD's goals. Grantees have the flexibility to select state-specific goals in any area of emphasis (e.g., employment, housing) to support ADD's long-term goals.

Evidence: The Act outlines specific measures as indicators of progress (Sec. 104(3)(D)(ii)(I-III)), which are required to be addressed in grantee plans (SCDD - Sec. 124(c)(4)(B)(I); P&As - Sec. 143(a)(2)(C); and UCEDDs - Sec. 153(a)(1)). Grantee Program Performance Reports.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: NO Question Weight: 12%

Explanation: Although ADD regularly reviews its grantees through audits and its Monitoring and Technical Assistance Review System, it does not undertake a regular independent evaluation of program effectiveness. ADD intends to conduct a design study of an independent evaluation in FY 2004 and to begin the independent evaluation of the three grant programs in FY 2005.

Evidence: Monitoring and Technical Assistance Review System Guidelines

Program Assessment Rating Tool (PART)

Program:	Developmental Disabilities Grant Programs
Agency:	Department of Health and Human Services
Bureau:	Administration for Developmental Disabilities
Type(s):	Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	75%	100%	25%	

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: SCDDs and P&As are formula grant programs determined on the basis of State population, per capita income, and estimates of individuals in the State with developmental disabilities. While ADD reviews data provided by grantees regularly, allocation of resources to particular priorities, based on statute, is influenced by individuals with developmental disabilities, families of and advocates for individuals with developmental disabilities. ADD sponsors forums and meeting to emphasize key areas of need and to recognize best practice, that often reinforce State-based priorities. Grantees participated in the drafting of ADD performance measures and are committed to long-term tracking of them.

Evidence: Administration on Children and Families' Annual Performance Plan and congressional justification.

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: ADD developed long-term and annual performance measures and targets. The Roadmap to the Future, ADD's strategic plan, is a document that is revised periodically in response to recommendations by programs and self-advocates, and authorizing legislation. Focus groups reviewed the strategic plan and reporting documents in response to the Act of 2000 and made recommendations to correct deficiencies. These recommendations have been implemented.

Evidence: FY 2005 Performance PlanRoadmap to the FutureRoadmap to the Future Update

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 11%

Explanation: SCDDs and P&As report data and performance electronically on an annual basis, while the UCEDDs submit their annual reports in paper copies. ADD also has an agreement to access annual data from the Association of University Centers on Disability's (AUCD) National Information Reporting System (NIRS), which includes data sets on trainees, projects, activities/impact and products. The data collected from these sources was being used by ADD to develop their performance measures baselines.Data are reviewed/approved and used for on-site monitoring by ADD staff. ADD's goal is to conduct on-site monitoring of 25-30 percent of States' grantees annually. ADD staff report their finding back to the State along with recommendations for management improvements. Electronic Data Systems (EDS) data reviews contribute to the determination of ADD's annual goals achievement. Program improvements are made through corrective action plans.

Evidence: ADD information gathered through monitoring is used to assist in the determination of non-compliance with the Act and in the provision of technical assistance. Grantee Annual Performance Reports.

Program: Developmental Disabilities Grant Programs
Agency: Department of Health and Human Services
Bureau: Administration for Developmental Disabilities
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	75%	100%	25%	

3.2 Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results? Answer: YES Question Weight: 11%

Explanation: The Secretary and ADD require fiscal and program accountability to ensure adherence to legislative intent. Program staff are responsible for monitoring the programs and assisting in the development and application of technical assistance. Federal accountability is also reflected in the Senior Manager's Performance Contract with the Assistant Secretary, and all staff performance plans, which are linked to the senior manager's performance. ADD will not release funds until the grantee submits an acceptable plan. Noncompliant grantees may be subjected to a designation of high risk status. Generally, when deficiencies are identified, corrective action plans are required and monitored. There are no monetary incentives built into the Act for superior performance.

Evidence: ADD manager performance contracts. Grantee Program Performance Reports (PPR).

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 11%

Explanation: ADD obligates funds to grantees in a timely manner, and limited funds remain unobligated at the end of the year. SCDDs, P&As and UCEDDs submit annual financial reports (SF-269s) and ADD conducts periodic on-site monitoring to ensure the funds are spent on their intended purposes. Program audits are performed by independent auditors in accordance with OMB Circular A-133 and other relevant OMB Circulars, and through PPRs by ADD staff.

Evidence: Financial management requirements. SF-269. Single State Audits.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: YES Question Weight: 11%

Explanation: While the program has implemented procedures to improve efficiency, there are no procedures in place by which to measure such efficiencies. For example, ADD is implementing an EDS to enable staff to collect, analyze and report data more efficiently. Over the past year, ADD experienced a reduction in staff and managed a large increase in grant activity. ADD is developing a meaningful efficiency measure.

Evidence: ACF Extranet Outsourcing Contract

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 11%

Explanation: ADD collaborates with other Federal agencies to ensure that (1) legal and advocacy services are coordinated and available to individuals with developmental disabilities; (2) related programs are jointly monitored; (3) technical assistance activities of related programs are coordinated to prevent overlap. ADD contributes to the coordination of programs and services to people with developmental disabilities through Federal councils and committees. SCDDs, P&As and UCEDDs are required to participate on the boards of their sister organizations, as well as collaborate with numerous state agencies, councils, and committees.

Evidence: Interagency Agreements with the Rehabilitation Services Administration and the Substance Abuse and Mental Health Services Administration for the provision of legal advocacy services. The Federal partners meet monthly with the Federal contractor to plan, develop and monitor the training and technical assistance activities provided, make joint decisions and evaluate the progress and outcomes of grantees.

Program Assessment Rating Tool (PART)

Program: Developmental Disabilities Grant Programs
Agency: Department of Health and Human Services
Bureau: Administration for Developmental Disabilities
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	75%	100%	25%	

3.6 Does the program use strong financial management practices? Answer: YES Question Weight: 11%

Explanation: The SF-269s are used to determine financial compliance with law and regulations. Staff review SF-269s to ensure expenditures and obligations are for authorized purposes.

Evidence: SF-269. Single State Audits. FIMA report

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 11%

Explanation: Annually ADD reviews of the Monitoring and Technical Assistance Review System (MTARS) Manual and monitoring procedures and makes revisions needed to improve the monitoring process and the provision of TA. ADD reviews all monitoring corrective action plans for concurrence with regulations. In 2001-2002, ADD conducted 21 monitoring visits resulting in corrective actions being implemented by grantees and two grantees being designated as 'high risk'. A 'high risk' designation confirms that substantial non-compliance issues have been cited with the potential for monetary restrictions until the grantee has corrected deficiencies. In cases involving corrective actions, ADD staff monitor compliance and engage in extensive technical assistance, and track action in corrective action plans.

Evidence: MTARS Manual and Monitoring Guide. On-site MTARS Reports.

3.BF1 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: YES Question Weight: 11%

Explanation: Grantees are required to submit program and financial reports annually, which describe goals and objectives undertaken and their outcomes.Monitoring of programs is conducted by ADD staff with the assistance of regional, consumer and peer reviewers. The monitoring process includes review of program documents, on-site reviews which include consultations with grantee staff and sub-grantees and contractors of grantees, and live town meetings to gather input from individuals with developmental disabilities and family members. This information is compiled in a final report of compliance, non-compliance and recommendations for grantee program and improvements. Grantees are monitored on a rotating basis, with 25-30% of grantees monitored each year. The quality of programs' data are not currently assessed; however, in FY2004, ADD intends to design an independent evaluation of the three programs.

Evidence: SF-269. Annual Program Performance Reports.Review of independent audits. On-site MTARS Reports.

3.BF2 Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner? Answer: YES Question Weight: 11%

Explanation: Program Performance Reports, State Plans (SCDDs and P&As) and Statements of Goals and Priorities are received via the EDS and made available to the developmental disabilities network. Information is also made available to the public through the Bi-Annual Report to President, Congress, and National Council on Disability; presentations at national meetings; progress reports on the President's New Freedom Initiative; and ADD's website. UCEDD data is collected by the TA contractor and put into NIRS. Grantee specific information is made public via the State agencies.

Evidence: Information is received and provided via EDS data sheets. ADD Web site (http://www.acf.dhhs.gov/programs/add/index.htm). Numerous publications produced by program components funded by ADD such as National Association of Councils on Developmental Disabilities, National Association of Protection and Advocacy Systems, the Association of University Centers on Disabilities.

Program ID: 10001056

Program Assessment Rating Tool (PART)

Program: Developmental Disabilities Grant Programs
Agency: Department of Health and Human Services
Bureau: Administration for Developmental Disabilities
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	75%	100%	25%	

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: ADD is in the process of implementing new performance measures. While data indicates that many of the prior goals were met some of the targets were not ambitious.

Evidence: ADD's Annual Reports to Congress and Reports from the Councils and P&As on achieving long-term and annual goals.

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: ADD is in the process of implementing new performance measures. In the past, ADD indicated that some if its annual performance goals were met (e.g., exceeded the prior employment goal) while others were not (e.g., did not meet housing goal). Some of the targets were not ambitious.

Evidence: ADD's Annual Report to Congress; Performance Reports from the Council and P&A grantees; and· UCEDD National Information and Reporting System.

4.3 **Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: While ADD has taken steps to improve efficiency, it cannot measure these efficiencies against established targets and baselines. Efforts such as implementing the EDS paperless reporting system have enabled ADD to manage increasing grant workloads while experiencing reductions in staff. ADD is working to develop a meaningful efficiency measure.

Evidence: ACF Extranet Outsourcing Contract

4.4 **Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?** Answer: NA Question Weight: 0%

Explanation: Although there are other programs that serve individuals with disabilities, including individuals with developmental disabilities, none are similar to ADD's role. ADD and its grantees provide technical assistance and collaborate with other Federal, State, and private entities with direct services responsibilities or interests. The work of ADD and its programs helps to ensure the effectiveness and responsiveness of other Federal, State, and local programs affecting the lives of individuals with developmental disabilities and their families.

Evidence:

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?** Answer: NO Question Weight: 25%

Explanation: A comprehensive, independent evaluation of ADD programs and grantees has not been conducted to date. In Fiscal Year 2004, ADD will issue a request for proposals to explore the feasibility and design of a national level program evaluation for ADD's grant programs. ADD will also ensure that the findings and recommendations from the FY2004 feasibility study and the resulting national evaluation of the three programs in future years are available to the public.

Evidence:

PART Performance Measurements

Program: Developmental Disabilities Grant Programs

Agency: Department of Health and Human Services

Bureau: Administration for Developmental Disabilities

Measure: By the end of FY 2007, the percentage of individuals with developmental disabilities who are independent, self-sufficient and integrated into the community, as a result of State Council efforts, will increase to 14 percent. (SCDD)

Additional Information: Percentage of individuals with developmental disabilities and their family members with positive outcomes as a portion of the national population. The national population of individuals with developmental disabilities (4,556,235) is based on Census Bureau data (7/1/02), and the estimated individuals with developmental disabilities population percentage of 1.58 percent as established by Gollay & Assoc. 2002 baseline of 12.94 percent.

Year	Target	Actual
2003	13.1%	
2004	13.2%	
2005	13.4%	
2006	13.7%	
2007	14.0%	

Measure Term: Long-term

Measure: Percentage of individuals with developmental disabilities who are more independent and self-sufficient as a result of employment, housing, transportation and health services. (SCDDs)

Additional Information: Percentage of individuals with developmental disabilities with positive outcomes as a portion of the national individuals with developmental disabilities population. 2002 baseline of 0.83 percent.

Year	Target	Actual
2003	0.84%	
2004	0.84%	
2005	0.87%	
2006	0.89%	
2007	0.91%	

Measure Term: Annual

PART Performance Measurements

Program: Developmental Disabilities Grant Programs

Agency: Department of Health and Human Services

Bureau: Administration for Developmental Disabilities

Measure: Percentage of children with developmental disabilities who are integrated through inclusive education, early intervention, and child care programs. (SCDDs)

Additional Information: Percentage of individuals with developmental disabilities with positive outcomes as a portion of the national individuals with developmental disabilities population. 2002 baseline of 2.62 percent.

Year	Target	Actual	**Measure Term:** Annual
2003	2.63%		
2004	2.67%		
2005	2.71%		
2006	2.77%		
2007	2.84%		

Measure: Percentage of individuals with developmental disabilities who have better quality services and supports.

Additional Information: Percentage of individuals with developmental disabilities and family members with positive outcomes as a portion of the national individuals with developmental disabilities population. Data provided from quality assurance portion of SCDD reports. 2002 baseline of 4.44 percent.

Year	Target	Actual	**Measure Term:** Annual
2003	4.45%		
2004	4.48%		
2005	4.62%		
2006	4.70%		
2007	4.82%		

Measure: By the end of FY 2007, the percentage of trained individuals who are actively working to improve access of individuals with developmental disabilities to services and supports will increase to 94 percent.

Additional Information: 2002 baseline of 92.26 percent.

Year	Target	Actual	**Measure Term:** Long-term
2003	92.51%		

PART Performance Measurements

Program: Developmental Disabilities Grant Programs

Agency: Department of Health and Human Services

Bureau: Administration for Developmental Disabilities

Measure: By the end of FY 2007, the percentage of trained individuals who are actively working to improve access of individuals with developmental disabilities to services and supports will increase to 94 percent.

Additional Information: 2002 baseline of 92.26 percent.

Year	Target	Actual	**Measure Term:** Long-term
2004	92.76%		
2005	93.13%		
2006	93.59%		
2007	94.10%		

Measure: Ratio of individuals with developmental disabilities and family members active in systems advocacy compared to individuals with developmental disabilities and family members trained in systems advocacy. (SCDDs)

Additional Information: 2002 baseline of 92.26 percent.

Year	Target	Actual	**Measure Term:** Annual
2003	92.51%		
2004	92.76%		
2005	93.13%		
2006	93.59%		
2007	94.10%		

Measure: Ratio of individuals with developmental disabilities and family members who access health care services compared to those who are trained regarding access to health care services. (UCEDD) [Targets Under Development]

Additional Information: This is a developmental measure. Baseline will be determined.

Year	Target	Actual	**Measure Term:** Annual
2003			

PART Performance Measurements

Program: Developmental Disabilities Grant Programs

Agency: Department of Health and Human Services

Bureau: Administration for Developmental Disabilities

Measure: By the end of FY 2007, percentage of individuals who have their complaint of abuse, neglect, discrimination or other human or civil rights corrected will increase from 87% to 93%. (P&As)

Additional Information: Percentage of complaints resolved. 2002 baseline of 87%

Year	Target	Actual	**Measure Term:** Long-term
2003	87.5%		
2004	88.0%		
2005	91.0%		
2006	92.0%		
2007	93.0%		

Measure: Percentage of individuals who have their complaint of abuse, neglect, discrimination or other human or civil rights corrected compared to total assisted. (P&A)

Additional Information: 2002 baseline of 87%

Year	Target	Actual	**Measure Term:** Annual
2003	87.5%		
2004	88.0%		
2005	91.0%		
2006	92.0%		
2007	93.0%		

Measure: Number of clients served by the P&A.

Additional Information: 2002 baseline of 25,064.

Year	Target	Actual	**Measure Term:** Annual
2003	25,127		

PART Performance Measurements

Program: Developmental Disabilities Grant Programs

Agency: Department of Health and Human Services

Bureau: Administration for Developmental Disabilities

Measure: Number of clients served by the P&A.

Additional Information: 2002 baseline of 25,064.

Year	Target	Actual
2004	25,127	
2005	25,441	
2006	25,817	
2007	26,317	

Measure Term: Annual

Program Assessment Rating Tool (PART)

Program: Domestic HIV/AIDS Prevention
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	86%	33%	17%	

1.1 Is the program purpose clear? Answer: Yes Question Weight: 20%

Explanation: CDC provides national leadership to prevent the acquisition and transmission of HIV infection through collaborations with community, state, national and other relevant partners.

Evidence: FY 2001 Program Briefing Mission Statement.

1.2 Does the program address a specific interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: There are still approximately 40,000 new infections occurring every year in the U.S. and approximately 400,000 people do not know their HIV status.

Evidence: Between early 1990's and 2000, CDC helped reduce perinatal transmission by approximately 90%. From late 1980's to 1990's number of new HIV infections dropped from approximately 120,000 to 40,000; however, the number of new infections has largely stayed at 40,000 for almost a decade.

1.3 Is the program designed to have a significant impact in addressing the interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: CDC provides the preponderance of funding for HIV prevention in the U.S. relative to state/local health departments and other non-governmental organizations. CDC also establishes public/private partnerships and leverages additional resources from its private partners.

Evidence: CDC does not know how much in total resources (state, non-governmental, local) is directed towards HIV prevention because states arent required to report this data, and it varies a lot by state. Based on a few studies, CDC roughly estimates that they provide 70 percent of the total HIV funding for prevention interventions such as counseling/testing versus 30 percent by other entities, and that they provide almost all of the funding for surveillance activities with states supplementing some of this funding. CDC has two pilots in MA/WI looking at the total resources devoted to HIV/Aids.

1.4 Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)? Answer: Yes Question Weight: 20%

Explanation: CDC provides national leadership on HIV prevention and is the major provider of funding, technical assistance, and capacity building at the Federal, state, and local levels. CDC works with states to produce national HIV/AIDS surveillance data and also conducts multidisciplinary and applied research. CDC partners with state/local health departments, state/local education agencies, and other non-governmental organizations to prevent HIV infection. CDC also develops and disseminates guidelines for counseling and testing activities and perinatal HIV prevention activities.

Evidence:

Program Assessment Rating Tool (PART)

Program: Domestic HIV/AIDS Prevention
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	86%	33%	17%	

1.5 Is the program optimally designed to address the interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: CDC funds activities at the local level through both direct and indirect (through state health departments) mechanisms and uses the direct funding to fill in gaps the indirect funding doesnt achieve. However, CDC is revisiting this issue, and having two separate streams of funding going to similar entities may not be the most efficient way to fund grantees.

Evidence: CDC provides funding to state health departments, who then fund specific local grantees to carry out prevention interventions. Priorities for state dollars are set through the community planning process to determine how states should allocate their funding; however, CDC has also directly funded community-based organizations through Congressional directives beginning in 1989, which has grown substantially under the Minority AIDS Initiative.

2.1 Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program? Answer: Yes Question Weight: 14%

Explanation: In 2003, CDC developed a new outcome measure to track the impact of the program on HIV infections, diagnosis and treatment. The central long-term outcome measure is: reduce by 25% the number of new HIV infections in the U.S. CDC will track progress initially based on the population <25 years of age until 2005, the first full year of national HIV incidence data. For example, almost all 50 states now implement HIV reporting (prevalence), and some states are reporting new infections (incidence). The number of people diagnosed with HIV under 25 was tracked first because this population is more likely to have been recently infected than those over 25 years of age. A measure of infections among minority populations is also being considered. On a long-term basis, CDC also tracks progress on increasing the proportion of HIV-infected people who know they are infected and increasing the proportion of HIV-infected people who are linked to appropriate prevention, care and treatment services.

Evidence: CDC's overarching long-term outcome goal is to reduce the number of new infections from 40,000. Until national HIV incidence data are available in 2005, CDC will track progress by focusing on the population under age 25. As the national incidence data become available, the baseline and target may be adjusted.

2.2 Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals? Answer: Yes Question Weight: 14%

Explanation: CDC's revision includes four annual performance goals. These goals that can currently be measured and are consistent with the long-term goals.

Evidence: The goals include reduce the number of HIV infection cases diagnosed each year among people less than 25 years of age, increase the proportion of HIV-infected people who know they are infected, increase the proportion of HIV-infected people who are linked to appropriate prevention, care and treatment services, and decrease the number of persons at high risk for acquiring or transmitting HIV infection, as measured by 12 month abstinence.

2.3 Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program? Answer: Yes Question Weight: 14%

Explanation: CDC requires quarterly reports from its directly-funded community-based organizations (CBOs) and annual reports from its funded state health departments. The progress reports must include the grantees goals, objectives, and performance reports which, while not explicitly linked to CDC's goals, are reasonably related to these goals.

Evidence: Examples of state objectives include increasing the number of outreach encounters. CDC indicates that some states have taken CDC's strategic plan and used it to develop their state plans. In new grant announcements for 2004, CDC plans to require states to report on CDC's indicators and targets.

Program: Domestic HIV/AIDS Prevention
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	86%	33%	17%	

2.4 Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives? Answer: Yes Question Weight: 14%

Explanation: While CDC has not historically collaborated with other agencies like HRSA very well, CDC has attempted to increase its collaborations with relevant Federal agencies.

Evidence: CDC collaborates with other Federal agencies on an as-needed basis to carry out relevant activities such as working with HRSA on surveillance and performance plan measures for people who are HIV positive, NIH on prevention research, and SAMHSA on addressing injection drug users. There is also an HHS-wide steering committee. The collaboration with NIH is the most involved since CDC has joint advisory committees and reviews research proposals.

2.5 Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness? Answer: Yes Question Weight: 14%

Explanation: While there are no regularly scheduled independent evaluations, CDC has had some comprehensive evaluations of its activities and programs over the past 10 years to help guide its activities and restructure its organization to improve its activities.

Evidence: In 2000, the IOM reviewed CDC and other HHS agencies HIV prevention activities to provide recommendations for how CDC and other agencies should improve their activities. Twice in the past 10 years, CDC has convened a external review panel to look at CDC's existing activities and provide recommendations for the future. The first led to a reorganization (merging surveillance with prevention programs), and the most recent one led to the current strategic plan. CDC also has some ongoing studies, including the HHS IG's audit of CDC's HIV prevention programs, an independent evaluation of CDC's minority aids activities (Maya Tech) and its directly-funded community-based organization activities (Urban). CDC also has an Advisory Council that meets several times a year to help CDC determine budget priorities and may issue reports.

2.6 Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known? Answer: No Question Weight: 14%

Explanation: It is unclear exactly what level of resources for each activity will be required to reach the goals, although CDC does align its GPRA goals with its funding levels. CDC's budget is currently aligned for financial accounting purposes, not for measuring performance. However, CDC does have an auxiliary budget system that tracks, after the fiscal year is over, the amount going towards the major activities of surveillance, prevention, research and policy evaluation, and does help inform CDC's strategic plan.

Evidence: Evidence includes GPRA plans and reports and budget justification documents.

Program Assessment Rating Tool (PART)

Program: Domestic HIV/AIDS Prevention
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	86%	33%	17%	

2.7 Has the program taken meaningful steps to address its strategic planning deficiencies? Answer: Yes Question Weight: 14%

Explanation: The program is working to refine the newly proposed limited number of specific, ambitious long-term performance goals. CDC is also taking steps to improve the integration of budget and performance information. CDC is considering new methods to forecast resource needs and more closely correlate available resources with program outputs and outcomes. For example, the program is considering developing an economic model on the costs of outreach, counseling and testing, including the marginal costs of harder to reach populations and those who have not been counseled and tested. CDC is also considering ways to better link resources to specific performance goals through the HIV Lead tracking system.

Evidence: Evidence includes newly submitted information from the agency. Steps CDC is taking to improve on the use of new long-term outcome measures include developing improved estimates of new HIV infections. Included in this effort is CDC's Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS).

3.1 Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance? Answer: Yes Question Weight: 9%

Explanation: CDC collects annual performance information from reports from grantees about their progress on meeting the objectives that they have developed in support of CDC's performance goals. When grantees are not performing, CDC uses this information to provide additional technical assistance. CDC also regularly collects data about disease rates and burdens and grantee activities to help guide its programs, and reallocates funds if grantees are not using funds consistent with the epidemic in their areas.

Evidence: CDC uses surveillance data to determine whether programs are having an impact on the rates of HIV infection and to identify emerging problems. States are required to track their dollars to the epidemic. CDC also uses the information it collects to work with projects to improve performance if programs are underperforming. For example, CDC worked with a grantee when the performance information indicated that the counseling and testing results were relatively low and therefore, may not have been reaching the highest at-risk population.

3.2 Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results? Answer: No Question Weight: 9%

Explanation: The program is not yet meeting the standard for this question for accountability of Federal managers, but is making progress. New efforts in place in 2003 have introduced meaningful accountability tools for program partners. Two to three Federal managers in the HIV center are SES and have performance-based contracts, but contracts are not in place for the program's managers. In 2003, CDC introduced a significant change to the program announcement to increase accountability among program partners. The program's largest grant announcement now specifies that partners are accountable for achieving target levels of performance established in their plans. Failing this performance, CDC will work with grantees to determine what steps can be taken to improve performance, such as through technical assistance, conditions or restrictions on use of funds, and reduction in funds in cases of chronic failure.

Evidence: Evidence of the new tools to advance accountability among program partners is included in the grant announcement in the July 10, 2003 Federal Register. Similarly, new community planning guidance to measure progress in achieving goals is forthcoming.

Program: Domestic HIV/AIDS Prevention
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	86%	33%	17%	

3.3 Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: No Question Weight: 9%

Explanation: Obligations: CDC obligates almost all of its funds by the end of the year. Most grantees have very little in unobligated balances at the end of the year. CDC's procurement and grants office allows all grantees to obligate any carry-over funds within the following fiscal year, but they must re-apply to use their carry-over funds. Spent for Intended Purpose: CDC's procurement and grants office does a cross check at the end of the year to determine whether grantees expenditures at the end of the year are consistent with their proposed budget. However, there have been some instances where the CDC grantees have not used funds for its intended purpose.

Evidence: Most grantees have a small percentage of their funds unobligated at the end of the year (a couple thousand dollars), but can request carry-over of these funds with their continuing application, and must use these funds in the next fiscal year. Grantees may have funding unobligated due to factors out of their control such as state legislators delaying the state's ability to spend Federal funds. CDC requires the quarterly reports and continuation applications to be consistent with the original application, and uses the annual progress report to compare to all previous documentation. If there are discrepancies, CDC will contact the grantee for an explanation or if necessary, carry out a site visit.

3.4 Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: No Question Weight: 9%

Explanation: The program has taken discrete steps to achieve efficiencies in program execution, but does not have incentives and procedures in place to improve efficiencies more broadly, including for example measures of efficiency of operations where appropriate. Examples of new efforts include CDC pursued a bulk purchasing of 250,000 OraQuick tests, reducing unit costs from $9-$14 to $8, to launch a new domestic HIV/AIDS effort. The program is also consolidating six program announcements for community-based programs into one announcement to reduce administrative burden and increase consistency. The program has also begun to transition the basic HIV/AIDS reporting system from DOS to Windows and anticipates efficiency gains as a result. The program is converting the counseling, testing and referral system from paper to internet based at the federal and state level.

Evidence: Most of CDC's current IT investments are geared towards program effectiveness, not cost efficiencies. CDC has developed an IT system to integrate program evaluation data from a wide range of data sources including health departments and CBOs. CDC intends to expand bulk purchasing of test kits. The grant announcement consolidation will be complete at the start of FY 2004 and the counseling, testing and referral system in January 2004.

3.5 Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels? Answer: No Question Weight: 9%

Explanation: While CDC includes all costs in the program, including overhead and administrative costs, and GPRA goals are aligned with funding levels, the HIV budget is not based on setting goals first and then determining funding levels to reach each of its goals. As described in Section II, CDC is taking steps to improve the integration of budget and performance information and more fully estimate and budget for the cost of operating the program.

Evidence: Specific steps include examination of the HIV Lead tracking system and economic modeling of program unit costs.

Program Assessment Rating Tool (PART)

Program: Domestic HIV/AIDS Prevention
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	86%	33%	17%	

3.6 Does the program use strong financial management practices? Answer: No Question Weight: 9%

Explanation: The FY 2002 report noted reportable conditions relating to information systems; the internal controls over preparation, analysis and monitoring of financial information, including manually intensive procedures; reimbursable agreements; and grants accounting and oversight. None of the reportable conditions are considered material internal control weaknesses. CDC has actively addressed key areas. CDC automated reimbursable billings, enhanced year end closing transactions and implemented a new indirect cost methodology. CDC is also addressing staffing needs, including core accounting competencies, professional staff recruitment, financial systems, training and customer service.

Evidence: Evidence includes the FY 2002 Chief Financial Officers annual report, including summary of reportable conditions, summary documents on end of year balances, OIG reports (e.g., CIN-A-04-98-04220), a report on indirect cost allocations from Capital Consulting Corporation, ATSDR and EPA region ten memorandum on site activities and cost recovery efforts. Four areas of findings were also documented the prior year. CDC has received five consecutive unqualified opinions on the agency's financial statements. Additional data include that CDC issued 64 duplicate or erroneous payments in FY 2002, or 0.042% of all payments and has a 97% compliance rate for prompt payments.

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: Yes Question Weight: 9%

Explanation: As noted above, CDC is actively addressing financial management. CDC and HHS are also conducting reviews of grantee activities to determine whether funds are being spent on their intended purpose. For example, CDC sampled two health departments and completed an internal assessment of directly funded community-based organizations. CDC has also recently notified grantees in instances when CDC determined funds were not spent for their intended purpose. CDC is also taking steps to improve accountability among program partners through reporting on one and five year targets and corrective action steps for failing to meet performance levels ranging from providing grantees additional technical assistance to discontinuing funding.

Evidence: The reviews CDC initiated encompassed an examination of 11 grantees and found some improvements were needed in developing guidelines and ensuring a science-base in grantee programming. The reviews provided the program with information that will be used to improve technical assistance and guidance and refine the agency's approach. Evidence of the new tools to advance accountability among program partners is included in the grant announcement in the July 10, 2003 Federal Register.

3.CO1 Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process? Answer: Yes Question Weight: 9%

Explanation: CDC convenes external panels for both its state health departments and directly-funded CBOs.

Evidence: For directly-funded community-based organizations, CDC convenes external Special Emphasis Panels (SEP) made up of external consultants (scientists, community representatives, health departments) who rank order the applications and give them a composite score. For state health departments, CDC convenes an outside objective review panel comprised of Federal employees who review applications based on written criteria and determine how much the applicant should receive.

Program Assessment Rating Tool (PART)

Program: Domestic HIV/AIDS Prevention
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	
100%	86%	33%	17%	Results Not Demonstrated

3.CO2 **Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?** Answer: Yes Question Weight: 4%

Explanation: N/A for state health departments since all 50 states have funding, and represent the largest proportion of funds going out from CDC. In terms of CDC's directly-funded CBOs, the fact that the same grantees are not successfully competing for Federal funds every year indicates that the process does encourage new grantees.

Evidence:

3.CO3 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: No Question Weight: 9%

Explanation: CDC has sufficient oversight of its grantees, but less oversight of its subgrantees, which has created some problems over the past several years. For its grantees, CDC has project officers who monitor grantee performance through conference calls, site visits, and review of progress reports and financial status reports. CDC indicates that it has little authority to collect information on subgrantee activities, and may collect limited information provided by the state health departments (the grantees) that may include the population served, the type of intervention, what organization is funded, and how much they have received. As described in Section II, CDC has taken additional steps to improve program oversight.

Evidence: 1. State Health Departments: Progress reports 2 times per year, continuation application, financial status report, and a final financial and performance report. 2. Directly-Funded CBOs: CDC requires quarterly progress reports, a continuation application, financial status report and a final financial and performance report, and at least one site visit per year.

3.CO4 **Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: No Question Weight: 9%

Explanation: While CDC has both aggregate and individual level performance data for its state health departments available publicly and highlights some grantee best practices, data on all directly-funded CBO grantees is not readily available publicly.

Evidence:

4.1 **Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?** Answer: No Question Weight: 25%

Explanation: CDC has proposed new long-term outcome measures, but does not yet have subsequent years of data to measure progress on the central outcome measure of reducing new HIV infections. Only the baseline year of data is available. While CDC has made progress overall on reducing the number of new infections from 120,000 in the late 1980's to 40,000 in the mid-1990's, this number has not changed over the past several years, and CDC's new performance goals are trying to get the number of new infections below 40,000.

Evidence:

Program Assessment Rating Tool (PART)

Program: Domestic HIV/AIDS Prevention
Agency: Department of Health and Human Services
Bureau: Centers for Disease Control and Prevention
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	
100%	86%	33%	17%	Results Not Demonstrated

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: Small Extent Question Weight: 25%

Explanation: CDC has developed new annual performance measures that contribute to the long-term goal of reducing HIV infections. A Small Extent is given because CDC has limited data available to measure progress.

Evidence: Evidence is included in the GPRA performance plan and agency submissions.

4.3 Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year? Answer: No Question Weight: 25%

Explanation: There are no measures of efficiency nor cost-effectiveness for this program. CDC's new initiative, "Advancing HIV Prevention: Strategies for a Changing Epidemic," has the potential to improve agency efficiency in meeting the program goals.

Evidence:

4.4 Does the performance of this program compare favorably to other programs with similar purpose and goals? Answer: N/A Question Weight: 0%

Explanation: There is no Federal program similar to CDC's that focuses on supporting the wide range of HIV prevention activities.

Evidence:

4.5 Do independent and quality evaluations of this program indicate that the program is effective and achieving results? Answer: Small Extent Question Weight: 25%

Explanation: While all of the evaluations indicate that CDC has made substantial progress on reducing the number of new infections from 120,000 in the late 1980s to 40,000 and reducing perinatal transmission, the IOM report and external review indicates that CDC's programs could go even further to try and reduce the 40,000 new infections and become more effective through redirection of some of its resources.

Evidence:

PART Performance Measurements

Program: Domestic HIV/AIDS Prevention

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Number of new HIV infections in the U.S.

Additional Information: Reduce by 25% as measured initially by <25 population from 2,100 in 2000 to 1,600 in 2010.

Year	Target	Actual	**Measure Term:**	Long-term
2000		Baseline		
2010	-25%			

Measure: Number of HIV infection cases diagnosed each year among people less than 25 years of age.

Additional Information: 1,900 cases over the 2000 baseline of 2,086

Year	Target	Actual	**Measure Term:**	Annual
2000		2,086		
2004	1,900			

Measure: Proportion of all HIV-infected people who know they are infected.

Additional Information: 80% over FY 1999 baseline of 70%

Year	Target	Actual	**Measure Term:**	Annual
1999		70%		
2004	80%			

Measure: Proportion of HIV-infected people who are linked to appropriate prevention, care and treatment services in all reporting areas

Additional Information: 80% in all reporting areas, from 9 of 16 areas in 2000

Year	Target	Actual	**Measure Term:**	Annual
2000		80% in 9 of 16 areas		
2004	80%			

PART Performance Measurements

Program: Domestic HIV/AIDS Prevention

Agency: Department of Health and Human Services

Bureau: Centers for Disease Control and Prevention

Measure: Number of new HIV infections in the U.S.

Additional Information: Reduce by 25% as measured initially by <25 population from 2,100 in 2000 to 1,600 in 2010.

Year	Target	Actual	**Measure Term:**	Long-term
2000		Baseline		
2010	-25%			

Measure: Number of HIV infection cases diagnosed each year among people less than 25 years of age.

Additional Information: 1,900 cases over the 2000 baseline of 2,086

Year	Target	Actual	**Measure Term:**	Annual
2000		2,086		
2004	1,900			

Measure: Proportion of all HIV-infected people who know they are infected.

Additional Information: 80% over FY 1999 baseline of 70%

Year	Target	Actual	**Measure Term:**	Annual
1999		70%		
2004	80%			

Measure: Proportion of HIV-infected people who are linked to appropriate prevention, care and treatment services in all reporting areas

Additional Information: 80% in all reporting areas, from 9 of 16 areas in 2000

Year	Target	Actual	**Measure Term:**	Annual
2000		80% in 9 of 16 areas		
2004	80%			

Program Assessment Rating Tool (PART)

Program: Food and Drug Administration
Agency: Department of Health and Human Services
Bureau: Food and Drug Administration
Type(s): Regulatory Based

Section Scores				Overall Rating
1	2	3	4	
100%	100%	100%	54%	Moderately Effective

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The Food and Drug Administration (FDA) has a very clear mission: to keep human drugs, vaccines, medical devices, animal drugs, and foods and cosmetic products safe. This mission, while applicable to a very wide range of products, is focused and well-defined.

Evidence: FDA Mission Statement: to promote and protect the public health by helping safe and effective products reach the market in a timely way, and monitoring products for continued safety after they are in use. Also, each FDA Center has their own specialized Mission Statement as well.

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: There is a clear need for a safe food supply and safe and effective human drugs, devices, vaccines, and animal drugs. The public health ramifications of foodborne illness are substantial, and certain populations, such as infants and the elderly, are more susceptible to foodborne illnesses. It is in the public interest to ensure that drugs, medical devices, and vaccines made available to the public are safe and effective given the high utilization rates of these products.

Evidence: CDC estimates that 76 million people get sick, more than 300,000 are hospitalized, and 5,000 Americans die each year from foodborne illness. Rapidly evolving technology used in products such as medical devices and human drugs increases FDA's role in reviewing new products for safety and effectiveness. Childhood vaccination utilization rates are very high in the U.S. -- vaccines are reviewed by FDA. It is estimated that 14 million units of blood are donated in the U.S. every year, and FDA is the Federal agency responsible for the safety of the blood supply.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: No State or local government agencies are responsible for the safety of prescription or over the counter drugs, medical devices, or vaccines. FDA is the sole agency responsible for ensuring the safety and effectiveness of these products. There is a State government role in food safety (through State Agriculture Departments). However, FDA provides Federal food safety standards, and facilitates international commerce. The Federal role in food safety is substantial.

Evidence: FDA plans to conduct at least 48,000 examinations of imported products in FY 2004. The FDA Center for Food Safety and Applied Nutrition (CFSAN) estimates that they regulate $1 for every $10 spent in the U.S. FDA reviews hundreds of applications for important new products such as medical devices, prescription drugs, and biologics every year, and it is FDAs responsibility to make sure that these products are available to the consumer as quickly as possible while still ensuring their safety and effectiveness.

Program Assessment Rating Tool (PART)

Program: Food and Drug Administration
Agency: Department of Health and Human Services
Bureau: Food and Drug Administration
Type(s): Regulatory Based

Section Scores				Overall Rating
1	2	3	4	
100%	100%	100%	54%	Moderately Effective

1.4 **Is the program design free of major flaws that would limit the program's effectiveness or efficiency?** Answer: YES Question Weight: 20%

Explanation: Current FDA structure is, in general, effective for the review of new drugs, devices, vaccines, and food additives. Given the legislative mandate of the FDA, and the wide range of products regulated by the agency, a system of compliance assistance and oversight is appropriate and effective. There are some inefficiencies present, such as the "triggers" for prescription drug and medical device user fess, that essentially preclude aggressive savings from management reforms. Also, while the fragmented structure of the Federal food safety system does not necessarily create duplications, it can result in some inefficiencies and complications.

Evidence: Pre-market review of new products ensures safety and effectiveness before the product is made available to consumers. Post-market activities ensure that products available on the market remain safe for consumer use, and are manufactured consistent with existing regulations.

1.5 **Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly?** Answer: YES Question Weight: 20%

Explanation: FDA funding is targeted effectively to achieve program purposes. The vast majority of FDA resources is devoted to the key activities of pre-market review of new products and post market surveillance of approved products. Central administrative funding for the agency is relatively low in relationship to the entire FDA budget.

Evidence: In FY 2003, funding devoted to central administration at FDA was less than seven percent of the entire agency appropriation. The vast majority of FDA appropriations are devoted to key agency functions.

2.1 **Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program?** Answer: YES Question Weight: 12%

Explanation: FDA has created a new set of long-term outcome goals that measure activities conducted at each program Center in the agency. The goals are intended to mesh with FDA's new Strategic Plan, and focus on several key FDA activities, including pre-market review, patient safety, consumer information, and counter-terrorism.

Evidence: The FDA FY 2005 Budget will include long-term outcome goals (with measurable targets). Selected long-term outcome goals include reducing the total time to market for new drugs, biologics, and devices; and increase the percentage of consumers who understand the relationship between dietary choices and coronary heart disease.

2.2 **Does the program have ambitious targets and timeframes for its long-term measures?** Answer: YES Question Weight: 12%

Explanation: FDA's new long-term outcome goals have ambitious targets and timeframes for completion. Many of these goals reflect areas where FDA performance has never been measured, making the goals and the targets more ambitious.

Evidence: The targets for the new long-term outcome goals will be detailed in the FY 2005 Performance Plan. These targets will be measurable, and will be compared to baseline data.

Program: Food and Drug Administration
Agency: Department of Health and Human Services
Bureau: Food and Drug Administration
Type(s): Regulatory Based

Section Scores				Overall Rating
1	2	3	4	
100%	100%	100%	54%	Moderately Effective

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 12%

Explanation: FDA has had annual performance measures for many years. These measures cover nearly every FDA activity. Many of these measures are mandated by the FDA authorizing statute, and others were created by FDA.

Evidence: The FDA FY 2005 Budget will include annual performance measures very similar to those found in recent years. Selected measures include: rates of inspection coverage at regulated manufacturing establishments, FDA decision times on pre-market review applications, and examinations of imported foods and other FDA-regulated products.

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: For pre-market review and inspection goals, performance targets are often set by statute, or in the case of user fee funded review activities, are negotiated with regulated industry in a "goals letter" that accompanies the user fee legislation.

Evidence: The annual FDA Performance Plan includes actual performance data going back several years to allow for a comparison of recent and proposed performance levels on annual performance goals.

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: FDA has established a protocol to ensure that all of its partners, whether contractors, partners or grantees, are committed to Agency long term goals in each initiative that is undertaken. This includes setting clear expectations on performance, agreement on a strategy to achieve performance goals, and monitoring.

Evidence: FDA has developed positive collaborations with the U. of Maryland on the Joint Institute for Food Safety and Applied Nutrition with clearly outlined performance expectations. The laboratory exchange network (eLEXNET) with States and other Federal agencies ties in tom FDA food safety-related goals. FDA outlines clear performance expectations for States involved in the inspection of mammography facilities.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: YES Question Weight: 12%

Explanation: FDA is a frequent subject of evaluations from the academic community, think tanks, and governmental agencies such as GAO and the HHS Inspector General. While evaluations generally cover the entire agency, certain areas, such as food safety, prescription drugs, and biologics, tend to receive more attention from evaluators.

Evidence: Several evaluations of FDA can be found on the websites of the GAO (www.gao.gov) and the HHS OIG (www.oig.hhs.gov).

Program Assessment Rating Tool (PART)

Program: Food and Drug Administration
Agency: Department of Health and Human Services
Bureau: Food and Drug Administration
Type(s): Regulatory Based

Section Scores				Overall Rating
1	2	3	4	
100%	100%	100%	54%	Moderately Effective

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: YES Question Weight: 12%

Explanation: Budget requests are made to assist FDA in the achievement of annual goals. The FY 2005 Budget will be the first year that long-term goals will be included, and this budget will be tied to the achievement of the new long-term outcome goals. Resources in the budget are transparently tied to agency activities.

Evidence: The annual FDA Performance Plan and the Congressional Budget Justification include data on the relationship between budget and performance estimates.

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: NA Question Weight: 0%

Explanation: FDA is strong in strategic planning. The creation of the new Strategic Plan spurred the formation of a detailed, lengthy list of actions items that create timelines and accountability for meeting the agency's long-term outcome goals and annual performance goals. One FDA Center, CFSAN, has been completing a similar "Program Priorities" report for several years. The CFSAN report details a wide range of goals and action items. The report is updated to show actual performance, and to explain how the goal will be met if performance is lower than expected.

Evidence: The new FDA Strategic Plan will be available by late July, 2003. The CFSAN Program Priorities report is made available o the public on the FDA Internet site. The web address for the most recent edition of the report is:http://www.cfsan.fda.gov/~dms/cfsan702.html

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 10%

Explanation: FDA collects a substantial amount of data on a variety of agency activities, and uses this data to manage agency performance. Detailed data are available on a range of pre-market review activities across the agency, and on rates of inspection coverage across FDA.

Evidence: The annual FDA Performance Plan includes a large amount of performance data and information. Much of this data is collected by field information systems, and other internal information tracking systems.

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 10%

Explanation: FDA managers are held accountable for achievement of the agency performance goals. FDA supervisors across the agency sign performance contracts, linking their evaluations with the achievement of performance goals. In cases where activities related to performance goals are contracted out to contractors (such as third party review of certain medical devices), activities are audited by the FDA.

Evidence: Many FDA managers across the agency have as part of their annual performance evaluations the successful management of their area's performance goals. Some FDA Centers link performance evaluations for managers to HHS-wide goals and the President's management Agenda.

Program ID: 10001057

Program: Food and Drug Administration
Agency: Department of Health and Human Services
Bureau: Food and Drug Administration
Type(s): Regulatory Based

Section Scores				Overall Rating
1	2	3	4	
100%	100%	100%	54%	Moderately Effective

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 10%

Explanation: Funds are obligated in a timely manner, and spent for the intended purpose. FDA monitors spending centrally and at each program Center to ensure that funds are obligated for intended purposes.

Evidence: In addition to the budget execution monitoring by the central FDA budget office, each Center has their own internal budget formulation and execution processes to ensure that funds are obligated for their intended purposes in a timely manner.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: YES Question Weight: 10%

Explanation: FDA has initiated an aggressive campaign to place many positions up for competitive sourcing. FDA has also stepped up efforts to use information technology to improve core agency functions, such as the review of new products, and the inspection of imported goods as they cross the border.

Evidence: The FDA Performance Plan for FY 2004 included annual performance goals measuring the use of IT in the review of new drugs and biologics, which dramatically streamlines the review process. The FY 2005 Performance Plan will introduce new agency-wide performance goals focused on management, including the competitive sourcing of 7.5% of non-governmental FTEs across the agency.

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 10%

Explanation: FDA maintains strong working relationships with partner agencies such as the US Department of Agriculture, the Centers for Disease Control, and the National Institutes of Health. FDA conducts many collaborative projects with these agencies.

Evidence: FDA partners with: USDA and CDC on food safety; AHRQ on patient safety; NIH on the Pest Pharmaceuticals for Children Act, drug development. FDA also collaborates with other governments on International Harmonization of product standards through the International Conference on Harmonization.

3.6 Does the program use strong financial management practices? Answer: YES Question Weight: 10%

Explanation: FDA has held a clean audit FDA has received clean audit opinions free of internal material control weaknesses for the past five years during audits completed by the HHS Office of the Inspector General.

Evidence: The FDA CFO Annual Report for FY 2002 provides a clean audit opinion free of internal material control weaknesses for FDA, and can be found on the FDA Internet site at: http://www.fda.gov/oc/oms/ofm/accounting/ofmaccounting.htm

Program: Food and Drug Administration
Agency: Department of Health and Human Services
Bureau: Food and Drug Administration
Type(s): Regulatory Based

Section Scores				Overall Rating
1	2	3	4	
100%	100%	100%	54%	Moderately Effective

3.7 **Has the program taken meaningful steps to address its management deficiencies?** Answer: NA Question Weight: 0%

Explanation: FDA takes a systematic approach to identifying management weaknesses, and making improvements if necessary. Under the Federal Manager's Financial Integrity Act (FMFIA), all managers must be involved in and assume responsibility for developing cost-effective management, assessing the adequacy of management controls, identifying improvements, and reporting annually on management improvements. Each FDA Center conducts internal compliance reviews and certifies compliance to the Center director. FDA is also involved in the Partnership for Administrative Quality, which is an annual audit to determine if proper controls exist to ensure the integrity of administrative programs. This review covers seven areas, including financial management, personnel, procurement, and property management.

Evidence: Detailed information on FDA's FMFIA activities can be found on the FDA website at: http://www.fda.gov/oc/reform/default.htm

3.RG1 **Did the program seek and take into account the views of all affected parties (e.g., consumers; large and small businesses; State, local and tribal governments; beneficiaries; and the general public) when developing significant regulations?** Answer: YES Question Weight: 10%

Explanation: FDA does a good job of considering the views of consumers, regulated industry, and other stakeholders when developing regulations. The FDA regulatory development process ensures the consideration of the views of all interested parties. It is often very challenging to balance the views of such a wide range of interested parties.

Evidence: FDA conducts many stakeholder meetings every year to discuss the development of regulations with the public. FDA solicits views from stakeholders in draft regulations and guidances. FDA often makes changes (sometimes significant changes) to regulations and guidances based on the comments received from stakeholders. FDA explains the agency position on stakeholders views in final regulations.

3.RG2 **Did the program prepare adequate regulatory impact analyses if required by Executive Order 12866, regulatory flexibility analyses if required by the Regulatory Flexibility Act and SBREFA, and cost-benefit analyses if required under the Unfunded Mandates R** Answer: YES Question Weight: 10%

Explanation: FDA conducts Regulatory Impact Analyses that comply with OMB guidelines. This data is often reviewed by external sources. FDA does report that in some instances, the decision to regulate is made in advance of the completion of an RIA.

Evidence: Example regulations: Hazard Analysis and Critical Control Point Systems for Fruit and Vegetable Juices (January, 2001), Safe Handling Statements and refrigeration of Shell Eggs (December 2000), Labeling Requirements for Over-the-Counter Drugs (March 1999).

3.RG3 **Does the program systematically review its current regulations to ensure consistency among all regulations in accomplishing program goals?** Answer: YES Question Weight: 10%

Explanation: FDA is starting to take a more active role in reviewing current regulations. FDA is moving in the right direction to ensure that regulations on the books are consistent and still relevant. However, further progress would be helpful, and a regularly scheduled regulatory review would further support this answer.

Evidence: Withdrawal of Certain Proposed Rules and Other Proposed Actions (68 FR 19766, April 22, 2003); Draft Guidance for Industry on "Part 11, Electronic Records, Electronic Signatures -- Scope and Application;" Availability of Draft Guidance and Withdrawal of Draft Part 11 Guidance Documents and a Compliance Policy Guide (68 FR 8775; February 25, 2003).

Program: Food and Drug Administration
Agency: Department of Health and Human Services
Bureau: Food and Drug Administration
Type(s): Regulatory Based

Section Scores				Overall Rating
1	2	3	4	
100%	100%	100%	54%	Moderately Effective

3.RG4 **Are the regulations designed to achieve program goals, to the extent practicable, by maximizing the net benefits of its regulatory activity?** Answer: YES Question Weight: 10%

Explanation: Regulations are designed to achieve program goals. FDA makes every attempt to maximize net benefits when developing and promulgating regulations. It is not always possible to maximize net benefits among a variety of options, since the best public health outcome may not always maximize net benefits. However, net benefits are always positive. FDA does try to balance these competing goals (public health and net benefits) as much as possible.

Evidence: Example Regulations: Requirements for Submission of Labeling for Human Prescription Drugs and Biologics (December 2000), Substances Prohibited from Use in Animal Food or Feed: Animal Proteins Prohibited in Ruminant Feed (June 1997).

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: NO Question Weight: 20%

Explanation: While FDA has created a new set of ambitious, measurable long-term outcome goals for the FY 2005 Budget, they are too new to show progress in meeting those goals. In some cases, baseline data is not yet available.

Evidence: FDA does have systems in place to create and gather baseline data to measure the success of their newly created long-term outcome goals. In some cases, improvements have been made in recent years in areas relating to the long-term outcome goals that will support improvements over the next few years. For the actual long-term outcome goals, see the Measures tab.

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: LARGE EXTENT Question Weight: 20%

Explanation: FDA does a good job meeting the annual goals included in its annual Performance Plan. Many of these goals are mandated by statute or are negotiated with industry. In some cases, goals are set lower than the statutory target due to competing priorities.

Evidence: See Measures tab for detail on the annual performance goals. The Measures tab has a sample of some of the key goals.

4.3 **Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** Answer: LARGE EXTENT Question Weight: 20%

Explanation: FDA has created new efficiency goals over the past several years that measure improved use of information technology in agency administrative processes, and in achieving management reforms such as competitive sourcing.

Evidence: In some cases, such as the review of generic drugs, improvements have been made in performance without new resources. FDA has already completed three sourcing competitions with positive results and cost savings. FDA efficiency should continue to improve with the new efficiency goals that FDA has implemented.

Program Assessment Rating Tool (PART)

Program: Food and Drug Administration
Agency: Department of Health and Human Services
Bureau: Food and Drug Administration
Type(s): Regulatory Based

Section Scores				Overall Rating
1	2	3	4	
100%	100%	100%	54%	Moderately Effective

4.4 **Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?** Answer: NA Question Weight: 0%

Explanation: FDA has a unique Federal role in regulating drugs, medical devices, and vaccines. While USDA does have a role in the regulation of food, the types of food that each agency has jurisdiction over are different. Therefore, this question does not apply to FDA.

Evidence:

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?** Answer: LARGE EXTENT Question Weight: 20%

Explanation: FDA is evaluated by a variety of outside organizations with frequency. The findings are primarily positive, but do reveal some weaknesses, particularly in some food safety areas and in blood safety.

Evidence: GAO and HHS OIG reports are available on the Internet. Results of these evaluations are generally positive, but do reveal some shortcomings. FDA has been praised by GAO for halting the dissemination of misleading prescription drug advertising, and for spending up the review of new drugs. Many of the criticisms of FDA in these reports are related to areas where the evaluators believe that FDA's legislative or regulatory authorities are not as strong or clear as they could be.

4.RG1 **Were programmatic goals (and benefits) achieved at the least incremental societal cost and did the program maximize net benefits?** Answer: LARGE EXTENT Question Weight: 20%

Explanation: FDA rules may not always maximize net benefits, but the benefits are indeed always greater than the costs of regulations. FDA works to keep costs to consumers low (if costs to consumers exist at all), but at times, costs to regulated industry can high. FDA is beginning efforts to review existing regulations to determine if they are appropriate for efficient science-based risk management.

Evidence: FDA does not always select regulatory options that maximize net benefits. In some cases, the option that presents the optimal public health outcome does not maximize net benefits -- even though net benefits are still positive. FDA is planning to review some existing regulations (such as regulations on review processes for new products) to determine if more efficient review practices would improve agency performance, and improve net benefits.

PART Performance Measurements

Program: Food and Drug Administration

Agency: Department of Health and Human Services

Bureau: Food and Drug Administration

Measure: Reduce administrative staff

Additional Information: This measure tracks FDA performance in reducing the amount of administrative support positions in all areas of the agency.

Year	Target	Actual
2004		3,086
2005	2,855	
2008	2,623	

Measure Term: Long-term (Efficiency Measure)

Measure: Number of labs to address surge capacity in the event of terrorist attack on the food supply.

Additional Information: This measure tracks FDA's ability to increase capacity to effectively analyze food samples for contamination in the event of a terrorist attack on the food supply.

Year	Target	Actual
2003	10	10
2004	10	10
2005	25	
2006	42	
2007	60	

Measure Term: Long-term

Measure: Inspect blood banks and biologics manufacturing establishments each year.

Additional Information: This measure tracks the percentage of blood banks and biologics manufacturing establishments inspected by FDA each year.

Year	Target	Actual
2001		57%
2002		52%
2003	50%	

Measure Term: Annual

PART Performance Measurements

Program: Food and Drug Administration

Agency: Department of Health and Human Services

Bureau: Food and Drug Administration

Measure: Inspect blood banks and biologics manufacturing establishments each year.

Additional Information: This measure tracks the percentage of blood banks and biologics manufacturing establishments inspected by FDA each year.

Year	Target	Actual	**Measure Term:** Annual
2004	50%		
2005	50%		

Measure: Inspect medical device manufacturing establishments each year.

Additional Information: This measure tracks the percentage of medical device manufacturing establishments inspected by the FDA each year.

Year	Target	Actual	**Measure Term:** Annual
2001		20%	
2002		20%	
2003	20%		
2004	20%		
2005	20%		

Measure: Reduce time to marketing approval for new drugs and biologics

Additional Information: This measure tracks the amount of months it takes for a new drug, or biologic to be approved for sale on the market, including both FDA review time and sponsor time.

Year	Target	Actual	**Measure Term:** Long-term
2001		18.9	
2007	16.9		

PART Performance Measurements

Program: Food and Drug Administration

Agency: Department of Health and Human Services

Bureau: Food and Drug Administration

Measure: Percentage of new drugs and biologic product reviews completed within 10 months.

Additional Information: This measure tracks the percentage of new drug and biologic applications that FDA reviews within the performance target.

Year	Target	Actual	**Measure Term:** Annual
2001		70%	
2002	90%		
2003	90%		
2004	90%		
2005	90%		

Measure: Percentage of medical device submissions that will receive final decisions within 320 review days.

Additional Information: This measure tracks the percentage of new medical device applications with final decisions completed within 320 days, including both FDA review time and sponsor time.

Year	Target	Actual	**Measure Term:** Long-term
2001		72%	
2006	80%		
2007	90%		

Measure: Percentage of FDA reviews of new medical devices completed within 180 days.

Additional Information: This measure tracks the percentage of new medical device applications that FDA reviews within the performance target.

Year	Target	Actual	**Measure Term:** Annual
2001		97%	
2002		97%	
2003	90%		
2004	90%		

PART Performance Measurements

Program: Food and Drug Administration

Agency: Department of Health and Human Services

Bureau: Food and Drug Administration

Measure: Reduce time to marketing approval for generic drug applications.

Additional Information: This measure tracks the amount of months it takes for a generic drug to be approved for sale on the market, including both FDA review time and sponsor time.

Year	Target	Actual	**Measure Term:** Long-term
2000		17.9	
2007	14.9		

Measure: Percentage of new generic drug application reviews completed in six months.

Additional Information: This measure tracks the percentage of generic drug applications that FDA reviews within the performance target.

Year	Target	Actual	**Measure Term:** Annual
2001		84%	
2002	65%	85%	
2003	80%		
2004	85%		
2005	90%		

Program Assessment Rating Tool (PART)

Program: Foster Care
Agency: Department of Health and Human Services
Bureau: Children's Bureau, ACYF, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	100%	26%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The title IV-E foster care maintenance payments (FCMP) program has a clear focus and a well-defined mission. Its focus, which is articulated in statute, is AFDC-eligible children who have to be removed from their homes as the result of abuse and/or neglect. Its mission is to provide board and care payments to licensed providers on behalf of these children.

Evidence: Sections 470 and 472 of the Social Security Act

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: Every year, approximately 565,000 children are in out-of-home care. Approximately 50% of them are title IV-E eligible.

Evidence: The Federal government assists States with a significant portion (50%-75%) of the costs related to a child's out-of-home care, as well as 50% of the associated administrative costs. The total cost of the title IV-E foster care maintenance program in FY 2001 was $8.312 billion, of which $4.395 billion was the Federal share.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: The title IV-E program is a Federal/State grant in aid program in which the Federal governement provides funds to augment the States administration of the program.

Evidence: No other Federal program of a similar nature exists. At the State level, the program is not, by design, duplicative. State child welfare agencies have statutory authority and responsibilty to remove children to foster care. This authority does not exist in the private sector.

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: NO Question Weight: 20%

Explanation: Many researchers and advocates have shown that the program's financial structure does not provide appropriate incentives for the timely, permanent placement of children. Since states are reimbursed for each IV-E eligible child in a foster care placement, federal support decreases for each child moved to a desired permanent placement such as adoption, reunification, or guardianship.

Evidence: See 1) Wulczyn, Fred. 2000. Federal Fiscal Reform in Child Welfare Services, Children and Youth Services Review, Vol.22 No. 2, 131-160; 2) Courtney, Mark. 1998. The Cost of Child Protection in the Context of Welfare Reform. The Future of Children, Vol. 8, No 1; and 3) Waldman, William. 2000. Hearing before the Subcommittee on Human Resources of the Committee on Ways and Means, House of Representatives, October 3, 2000.

Program ID: 10000308

Program Assessment Rating Tool (PART)

Program: Foster Care
Agency: Department of Health and Human Services
Bureau: Children's Bureau, ACYF, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	100%	26%	

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: The program is effectively targeted to ensure that the intended beneficiaries receive the appropriate resources to address the purpose of the title IV-E foster care program. The statute at sections 472(a) and 475(4) clearly lays out the child eligibility requirements that will result in a foster care maintenance payment, the purposes of which (food, clothing, shelter, etc.) are also clearly defined in statute.

Evidence: Social Security Act, sections 472(a) and 475(4) and 45 CFR 1355.20, 1356.21, 1356.22, 1356.30, 1356.71. The title IV-E eligibility reviews are conducted to ensure that foster care maintenance payments are made on behalf of eligible children. As of summer 2003, twenty-five (68%) of the thirty-seven States reviewed to date (including those reviews conducted in each of FYs 2000-2003) were determined to be in substantial compliance with Federal requirements. States that did not meet the compliance threshold were required to complete a Federally approved plan that addressed non-compliant program areas and undergo a more extensive, secondary level of program review. Thus far, two secondary reviews were conducted and fifty percent of the States were determined to meet the compliance threshold.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation: The Children's Bureau has established two new long-term performance measures. 1) By federal fiscal year 2008, the Child and Family Services Review (CFSR) process will have resulted in the States demonstrating continuous improvement by having 90% (328) of the individual outcomes that they are expected to achieve (364 total) remaining penalty free (meaning that the target established in the national performance standard has been met).2) Of those children whose permanency plan is adoption, 327,000 will be adopted with public child welfare involvement between FY 2003 and FY 2008.

Evidence: FY 2005 HHS GPRA Plan.

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation: Both the CFSR review measure and the adoption measure are ambitious. First, no State has been found in substantial conformity with each CFSR review outcome to date. In fact, since ninety percent of the CFSR outcomes reviewed to date are subject to penalty (only 10% are penalty free), the 90% target (328 = ((7 outcomes x 52 states/terr.) x 90%) of penalty free outcomes is ambitious. Second, to achieve a cumulative 327,000 adoptions from 2003-2008, the number of adoptions must increase by a at least 1,000 each year. This will result in an adoption rate (which is the number of adoptions divided by the number of children in foster care at the end of the prior year) of 12% in FY 2008, a rate fully one-third higher than the current adoption rate of 9%. This is a very ambitious goal because the number of adoptions must increase while the number of children in foster care decreases.

Evidence: FY 2005 HHS GPRA Plan.

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: YES Question Weight: 12%

Explanation: The Children's Bureau has established quantifiable annual performance measures related to the safety of children in foster care and achieving permanence and stability for children in foster care. Annual performance measures are directly related to long-term performance measures. For example, there are annual targets for moving to adoption. The annual targets are the same outcomes by which states are assessed in the CFSR.

Evidence: FY 2005 HHS GPRA Plan.

Program ID: 10000308

Program Assessment Rating Tool (PART)

Program: Foster Care
Agency: Department of Health and Human Services
Bureau: Children's Bureau, ACYF, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	100%	26%	

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: The annual targets present ambitious progress toward the Children's Bureau's National Standards in light of two important considerations. First, setting numeric targets in child welfare is a delicate task because of the danger of unintended consequences. Second, many states and counties will need to improve performance to achieve even these increases in the national measures.

Evidence: FY 2005 HHS GPRA Plan.

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: All States support program planning efforts by submitting to the Child & Family Service Reviews (CFSRs), which require states to report data on outcomes annually. States also commit to and work toward performance goals by developing Performance Improvement Plans (PIPs) when improvements are required due to substandard performance (defined as performance levels below the National Standards identified in 2.4). States report data to the National Child Abuse & Neglect Data System (NCANDS) and the Adoption & Foster Care Analysis & Reporting System (AFCARS).

Evidence: The Child Abuse Prevention & Treatment Act (CAPTA); sections 479 and 479A of the Social Security Act; section 1123A of the Social Security Act; section 203 of P.L. 105-89.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: NO Question Weight: 12%

Explanation: No reports examine overall program effectiveness. Reports on the title IV-E foster care program by GAO and the Office of the Inspector General (OIG) have examined specific components of the program. Findings are generally consistent with those of the CFSR and Title IV-E reviews which are addressed through the PIP mechanism.

Evidence: N/A

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: Due to the current financial structure of the program, the budget is not directly aligned with program goals. The full cost of the program is accounted for through States submission of claims utilizing the form IV-E-1.

Evidence: N/A

Program Assessment Rating Tool (PART)

Program: Foster Care
Agency: Department of Health and Human Services
Bureau: Children's Bureau, ACYF, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	100%	26%	

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: The Chlidren's Bureau has used the results of the CFSR and improved data from the AFCARS to set long-term measures and more ambitious performance targets.

Evidence: The selection of these goals is based on trend data derived from the Adoption and Foster Care Analysis and Reporting System (AFCARS) and on the findings from states being reviewed through the Child and Family Services Reviews. For adoption, the federal government provides incentive funds to states that increase their number of children being adopted. In addition, the federal government conducts the Child and Family Services Reviews and provides training and technical assistance to states for the second long-term goal. These activities also have an impact on the first long-term goal. The goals are as follows: 1. By federal fiscal year 2008, the Child and Family Services Review (CFSR) process will have resulted in the States's demonstrating continuous improvement by having 90% (328) of the individual outcomes that they are expected to achieve (364 total) remaining penalty free. 2. Of those children who have the permanency goal of adoption, three hundred thousand (300,000) will be adopted with public child welfare involvement between FY 2003 and FY 2008.

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 12%

Explanation: ACF conducts a variety of reviews to assess State performance. States determined not to be in substantial conformity with either a CFSR or title IV-E review enter into a detailed program improvement plan. Additionally, the Children's Bureau utilizes a partial review process to address compliance issues that are outside the scope of a formal review protocol. States enter PIPs as a result of partial reviews, as well.

Evidence: By the end of FY 2002, 32 CFSR and 31 title IV-E eligibility reviews have been completed.

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 12%

Explanation: The Division director and team leader have been identified as responsible for oversight of the foster care program through ACF regional offices, in accordance with ACF's Statement of Organization and Functions. Performance standards are defined in employees performance plans. States are held accountable through monitoring, joint planning with the regional offices, and regional office reviews of form IV-E-1.

Evidence: Staff EPMS plans specify relevant objectives, including the scheduling of and participation in on-site reviews; performance is rated accordingly. The Children's Bureau has provided the results of Monitoring Activities including Title IV-E Reviews Completed.

Program ID: 10000308

Program: Foster Care
Agency: Department of Health and Human Services
Bureau: Children's Bureau, ACYF, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	100%	26%	

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 12%

Explanation: Funds are obligated in a timely manner. ACF issues grant awards based on financial data submitted by States on the financial expenditure form (ACYF-IV-E-1). Quarterly expenditure reports are scrutinized to ascertain what costs are being claimed by grantees and if they are being expended appropriately. Funds that are expended inappropriately are disallowed. If the disallowance is appealed and sustained, the disallowance is adjusted in a subsequent grant award sent to the State. As part of the audit resolution process, grantees must agree to implement recommendations made in the audit disallowance letter sent to them by the ACF Grants Office and indicate when required corrective action has occurred.

Evidence: Funds that are expended inappropriately are disallowed. If the disallowance is appealed and sustained, the disallowance is adjusted in a subsequent grant award sent to the State. The Children's Bureau also issues policy guidance to address inappropriate claiming issues, as is evidenced by PA-01-02. Title IV-E is an entitlement program whereby States are reimbursed for allowable expenditures. Federal funds are only dispersed as they are claimed. It is not possible for funds to go unobligated. In addition, States have a period of two years in which to file claims for reimbursement negating the need to establish a structured schedule to determine whether reimbursement corresponds to program need. ACF ensures that funds are expended for intended use through title IV-E eligibility reviews, state and OIG audits, and regional office assessment of claims.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: NA Question Weight: 0%

Explanation: The program does have procedures in place to promote efficiency gains, such as adoption incentive payments to states and incentives for states to develop Statewide Automated Child Welfare Systems (SACWIS). However, because the purpose of the program is to protect the lives of children who have been subject to abuse and/or neglect, the establishment of a national efficiency goal raises the danger of perverse pressures that could endanger the lives of abused and neglected children.

Evidence: Title IV-E of the Social Security Act, Section 473A. Section 13713 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) (Pub. L. 103-66); Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272); Statewide Automated Child Welfare Information Systems (SACWIS) provisions under Title IV-E of the Social Security Act at Section 474(a)(3); 45 CFR 1355 and 1356; 45 CFR 95 Subparts E, F, and G;

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 12%

Explanation: Through the CFSR, the Children's Bureau (CB) assesses the efficacy of a State's collaborative efforts with other public and private agencies that serve the same general population. At the Federal level, ACF collaborates with various agencies in developing policies that cut across more than one Federal program.

Evidence: To date, only one state that has undergone a Child and Family Service review has not been in substantial conformity with the requirement to collaborate with agencies who share common goals. ACF has issued policy in coordination with the Child Support program, Office of Refugee Resettlement, Office for Civil Rights and the Centers for Medicare and Medicaid (CMS) to give guidance to the field regarding how the requirments of the different programs impact State child welfare systems.

Program ID: 10000308

Program Assessment Rating Tool (PART)

Program: Foster Care
Agency: Department of Health and Human Services
Bureau: Children's Bureau, ACYF, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	100%	26%	

3.6 Does the program use strong financial management practices? Answer: YES Question Weight: 12%

Explanation: Financial management practices presently in place for the foster care maintenance payments program include title IV-E eligibility reviews (through which ACF employs a 10% error threshold), state and IG audits, and regional office assessment and resolution of state claims. In addition, ACF intends to develop and publish a national error rate for title IV-E and publish state performance with respect to it on an annual basis. In addition, ACF submits to an audit annually.

Evidence: Twenty-five (68%) of the thirty-seven States reviewed to date under the title IV-E eligibility reviews were determined to be in substantial compliance with Federal requirements. States that did not meet the compliance threshold were required to complete a Federally approved plan that addressed non-compliant program areas and undergo a more extensive, secondary level of program review. Thus far, two secondary reviews were conducted and fifty per cent of the States were determined to meet the compliance threshold. Moreover, Clifton Gunderson LLC's ACF FY 2002 audit was clear of material weaknesses.

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 12%

Explanation: Contractors are in the process of finalizing data bases that will allow for the collection and aggregation of data resulting from the Child and Family Service Reviews and the foster care eligibility reviews. This data will be input following the completion of each review and will provide vital information on the individual and collective strengths and weaknesses of States. This information will prove very useful in devising new management strategies and directing technical resources, where needed. The Children's Bureau convenes a quarterly conference call with ACF regional office program and fiscal staff to discuss management issues. Calls have focused on recent Departmental Appeals Board decisions, disallowance actions taken in States and the reasons why, and instructions on how to review and analyze quarterly expenditure reports from grantees.

Evidence: Regional office staff consult with Children's Bureau staff with questions and/or problems that arise within their regions. Feedback from various regions alerts central office staff to what may be a pervasive problem, enabling them to develop a response appropriate to the issue. Once information from the on-site reviews is entered into a data base, reports can be developed to be used intermittently and cumulatively. This is another type of management tool that will prove useful in identifying trends and patterns among States.

3.BF1 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: YES Question Weight: 12%

Explanation: Refer to Question III.3.1. Both the foster care eligibility reviews and the Child and Family Service Reviews emphasize teamwork and partnering between Federal and grantee staff, since the teams that conduct the reviews are comprised of both Federal and State employees.

Evidence: Refer to question III.3.1. Quarterly expenditure reports are submitted to ACF regional offices for review and approval. Site visits are conducted every 3 years if States are determined to be in substantial compliance with foster care eligibility requirements. Otherwise, a second review is conducted within a year and a half of the first one. For CFSR, a State is reviewed every 5 years if found to be in substantial conformity with State plan requirements. If not, a subsequent review is conducted 2 years following the approval of its PIP. A Statewide Assessment is conducted 3 years after the completion of an on-site review, as well. The quality of AFCARS data continues to improve, as the need for good data (based on its uses) is recognized by the State agencies. Technical assistance provided by the CB's network of national resource centers, and resulting from AFCARS assessment reviews and CB's data team efforts, has contributed markedly to an increase in data quality.

Program: Foster Care
Agency: Department of Health and Human Services
Bureau: Children's Bureau, ACYF, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	100%	26%	

3.BF2 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: YES Question Weight: 12%

Explanation: Program performance is publicized in the following ways: CFSR Reports; Child Welfare Outcomes Report; AFCARS data. AFCARS data is submitted semi-annually from States to ACF. States are automatically sent data quality and compliance reports to provide them with feedback on their submission. Data collected during on-site reviews are input into data bases by ACF staff for review and analysis.

Evidence: The CFSR Final Reports, Child Welfare Outcomes Report and AFCARS data reports are available on the Children's Bureau website. www.acf.dhhs.gov/programs/cb

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: SMALL EXTENT Question Weight: 33%

Explanation: The CFSR measure is newly developed, and so progress cannot yet be demonstrated. The current long-term adoption measure defined success as doubling the number of adoptions to 56,000 in FY 2002 (from 26,000 in FY95), and the program is on track for 51,000 adoptions in FY02. However, the program exceeded its long term adoption goal in the aggregate over the period FY99 to FY02.

Evidence: It is expected that 51,000 adoptions will have been finalized in FY 2002, below the 56,000 target for FY 2002. However, the GPRA goal for the cumulative number of adoptions from FY 1999 to FY 2002 was 194,000 (FY 1999=41,000, FY 2000=46,000, FY 2001=51,000, FY 2002=56,000) The total number of adoptions actually finalized during this period, 200,000 (FY 1999=47,000, FY 2000=51,000, FY 2001=51,000, FY 2002=51,000) exceeded the total targeted in the GPRA by 6,000.

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: SMALL EXTENT Question Weight: 33%

Explanation: In FY 2002, 2 of 4 targets for which data is available were clearly met (percentage of children adopted and percentage of children with no more than 2 placement settings). Of the remaing two measures, it is not anticipated that the goal for adoptions will be met: 51,000 adoptions achieved rather than the target of 56,000. The data for repeated substantiated reports of maltreatment is not yet available for CY02, but the data trends from CY98 to CY01 show increases from 8% to 9%, not maintenance of 7%.

Evidence: GPRA Annual Performance Plan

4.3 **Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** Answer: NA Question Weight: 0%

Explanation: The program does have procedures in place to promote efficiency gains, such as adoption incentive payments to states and incentives for states to develop Statewide Automated Child Welfare Systems (SACWIS). However, because the purpose of the program is to protect the lives of children who have been subject to abuse and/or neglect, the establishment of a national efficiency goal raises the danger of perverse pressures that could endanger the lives of abused and neglected children.

Evidence: Title IV-E of the Social Security Act, Section 473A. Section 13713 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) (Pub. L. 103-66); Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272); Statewide Automated Child Welfare Information Systems (SACWIS) provisions under Title IV-E of the Social Security Act at Section 474(a)(3); 45 CFR 1355 and 1356; 45 CFR 95 Subparts E, F, and G;

Program: Foster Care
Agency: Department of Health and Human Services
Bureau: Children's Bureau, ACYF, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	75%	100%	26%	

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?

Answer: NA Question Weight: 0%

Explanation: No comparable programs exist.

Evidence:

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?

Answer: NO Question Weight: 33%

Explanation: No reports examine overall program effectiveness. Reports on the title IV-E foster care program by GAO and OIG have examined specific components of the program. Findings are generally consistent with those of the CFSR and Title IV-E reviews which are addressed through the PIP mechanism.

Evidence: The Child Welfare Program Option proposed in the President's FY 04 budget contains a requirement, and the requisite funding, to evaluate States that participate in the option.

Program ID: 10000308

PART Performance Measurements

Program: Foster Care

Agency: Department of Health and Human Services

Bureau: Children's Bureau, ACYF, ACF

Measure: Percent of penalty free CFSR outcomes

Additional Information: This measure tracks State performance in completing program improvement plans related to the Child and Family Services Review outcomes.

Year	Target	Actual	**Measure Term:**	Long-term
2008	90%			

Measure: The cumulative number of adoptions from the public child welfare system, 2003-2008.

Additional Information:

Year	Target	Actual	**Measure Term:**	Long-term
2008	327,000			

Measure: Decrease the percentage of children with substantiated reports of maltreatment that have a repeated report within six months.

Additional Information: This measure tracks state performance in keeping children safe following an incident of maltreatment

Year	Target	Actual	**Measure Term:**	Annual
2000		9%		
2001	7%	9%		
2002	7%			
2003	7%			
2004	7%			

Measure: Maintain the percentage of kids who exit foster care to reunification within six months

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2004	67%			
2003	67%			

PART Performance Measurements

Program: Foster Care

Agency: Department of Health and Human Services

Bureau: Children's Bureau, ACYF, ACF

Measure: Maintain the percentage of kids who exit foster care to reunification within six months

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2002	67%	68%		
2001	67%	68%		
2000	67%	67%		

Measure: Increase the percentage of kids who exit foster care to adoption within two years

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2004	27%			
2003	25%			
2002	25%	25%		
2001	28%	23%		
2000	27%	20%		

Measure: Maintain the percentage of children who exit foster care through guardianship within two years of entering placement.

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2004	62%			
2003	60%			
2002	60%	62%		
2001	67%	57%		

PART Performance Measurements

Program: Foster Care

Agency: Department of Health and Human Services

Bureau: Children's Bureau, ACYF, ACF

Measure: Maintain the percentage of children who exit foster care through guardianship within two years of entering placement.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2000	67%	59%	

Measure: Increase the number of adoptions

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2004	60,000		
2003	58,500		
2002	56,000	9/2003 (51,000 exp.)	
2001	51,000	51,000	
2000	46,000	47,000	

Measure: For those children who had been in foster care less than 12 months, increase the percentage that had no more than two placement settings.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2000		82%	
2001	72%	83%	
2002	60%	81%	
2003	62%		
2004	80%		

OMB Program Assessment Rating Tool (PART)

Competitive Grant Programs

Name of Program: Head Start

Section I: Program Purpose & Design (Yes,No, N/A)						
	Questions	**Ans.**	**Explanation**	**Evidence/Data**	**Weighting**	**Weighted Score**
1	*Is the program purpose clear?*	yes	Head Start's (HS) purpose of enhancing school readiness is clearly defined in the Head Start Act and in several other policy documents.	Section 636 of the Head Start Act (42USC 9801)	20%	0.2
2	*Does the program address a specific interest, problem or need?*	yes	38% of fourth graders cannot read at basic levels, 64 percent of African-American students and 60 of Hispanic children cannot meet basic levels. (NCES -1998) Low reading levels are correlated with high drop-out, substance abuse and criminal activity.	Poor children who attend intensive preschool classes are more likely to graduate from high school and less likely to be arrested than poor children not in programs. JAMA May 2001	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	yes	HS will serve an estimated 850,000 low-income 3 and 4-year olds, more than 60% of the eligible children nationwide. Nationwide, 70% of all 4-year olds are in some formal pre-K setting.	Head Start classrooms are ranked higher than other pre-school programs on criteria related to effectiveness. Family and Child Experiences Survey (FACES) 2001	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	yes	Low-income children are less likely to be in pre-K programs than higher income children, however there is increasing evidence that HS is having difficulty filling slots for four year olds, in part due to expansion of State pre-K systems.	States spend an estimated $1.9 billion on pre-K programs, the Federal cost of HS (80% of total costs) is $6.5 billion in FY 2002.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	no	The standards to increase school readiness have yet to be fully and effectively implemented. Individual HS programs are not evaluated on whether they effectively prepare children for school.	Children in HS gained in word knowledge, but little in letter recognition and remained below the non-HS pre-K population.	20%	0.0
Total Section Score					**100%**	**80%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning (Yes,No, N/A)						
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	no	While performance goals are linked to the program's purpose, measuring average gains across students obscures the results of successful and unsuccessful programs. Long-term goals don't call for ambitious improvements over current performance. ACF is developing measures that would track the success of individual grantees in improving the school readiness of HS children.	Current long-range goals call for no or only modest increases in a number of measures. Goals currently focused on process measures should be strengthened. Goals under development will increase the focus on program outcomes and will provide grantee specific measures.	17%	0.0
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	yes	ACF's annual GPRA plan includes a number of quantifiable annual goals, the majority of which focus on outcomes.	The annual goals call for a 32% gain in word knowledge, 52% gain in mathematical skills and 70% gain in letter recognition.	17%	0.2
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	yes	All Head Start grantees are required to assess child outcomes using a number of indicators including: phonemic, print and numeracy awareness, language, vocabulary, book appreciation, acquisition of English, for non-English speaking children, letter knowledge, word recognition, and other measures related to school readiness.	Although the results of these assessments are not currently reported to HHS, steps are underway to have all 1,525 grantees report information on all enrolled children by September 2003.	17%	0.2
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	no	HS has established coordination offices in each State that work to integrate HS services with child care programs and other early education services, however, systems remain fragmented and don't meet the needs of working parents.	GAO T-HEHS-98-183 Head Start Challenges Faced in Demonstrating Program Results and Responding to Societal Changes	17%	0.0
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	yes	Two national evaluations are currently being conducted of the Head Start program to measure its success in preparing children for school.	FACES; National Impact Study . Also Head Start PIR, monitoring data and annual audits.	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	no	Current HS law requires that a portion of any increase in funding go towards activities that are intended to increase program quality and improve child outcomes. However, these inputs are not directly linked to performance. HHS is implementing a system to assess the performance of individual grantees and make subsequent grant allocation decisions based on this information.	Assessments of individual grantees could be used to determine if grants should be recompeted and to inform the use of training and technical assistance funds that are now distributed by formula.	17%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	n/a			0%	
Total Section Score					**100%**	**50%**
Section III: Program Management (Yes,No, N/A)						
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	yes	All Head Start programs submit annual reports on their program, including many items related to performance. In addition, all programs are monitored on-site at least once every three years. Data from these efforts help guide policy decisions. HHS is implementing a system to report child outcome data by grantee by September 2003.	HHS uses administrative data, annual monitoring data, annual audits, and survey data from representatives samples of centers to monitor program performance. Monitoring is used to assess grantees and provide targeted technical assistance.	9%	0.1
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	no	Grantees are only held accountable for achieving specified minimum levels of performance in order to continue receiving a Head Start grant. While unsuccessful programs are replaced, there is no link between performance and budget for programs exceeding minimum standards.	Since 1993, more than 150 Head Start programs have been replaced because of quality related problems.	9%	0.0
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	yes	Head Start grantees must obligate funds in a timely manner to assure the continued provision of services to children and families.	Head Start obligates virtually 100% of funds appropriated.	9%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	no	Head Start performance targets do not include efficiency measures. Several provisions of Head Start authorizing legislation require unit costs to rise on an annual basis and are beyond the control of ACF	HS law requires that increases in funding must provide COLA adjustments to grantees. 25% of the remaining increment above the prior funding level funds quality improvements, typically increased teacher salaries. Any remaining funds are used to serve additional children.	9%	0.0
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	no	The program's annual budget requests in such a way that the full annual costs of associated with achieving annual goals (other than input based measures) cannot be determined through the information provided in the budget submission.	Administration for Children and Families, OMB Budget Submission	9%	0.0
6	*Does the program use strong financial management practices?*	yes	Data from the HS Monitoring and Tracking System (HSMTS) found that less than 4% of programs had findings related to erroneous payments. Only one of 44 agencies reviewed resulted in a monetary finding.	ACF review of erroneous payments under Head Start	9%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	yes	One-third of all Head Start grantees are subject to on-site monitoring each year and grantees that don't meet minimum performance levels are replaced.	Since 1993, more than 150 Head Start programs have been replaced because of quality related problems, including management deficiencies.	9%	0.1
8 (Co 1.)	*Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?*	yes	When new grants are awarded, or recompeted, all applications are reviewed by an independent panel and funding decisions are based on the results of that review.	Section 641 of the Head Start Act lays out the criteria for assessing the potential of grantees to deliver Head Start services.	9%	0.1
9 (Co 2.)	*Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	no	Head Start grantees, as required by law, receive indefinite project periods so funds are awarded competitively only in situations where a grantee is being replaced or where expansion funds are being allocated on a competitive basis.	Section 641 of the Head Start Act gives preference to grantees currently receiving HS funds, organizations that served as HS delegate agencies. Only if these conditions are not met can other groups compete.	9%	0.0

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
10 (Co 3.) *Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	yes	All Head Start grantees are monitored on-site at least once every three years. Annual audits must be submitted by every Head Start program. In addition, federal staff have regular and continual contact with grantees.	Annual Head Start monitoring report. The Head Start budget sets aside over $24 million to conduct program monitoring.	9%	0.1
11 (Co 4.) *Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	no	Currently, performance data is collected from programs via the PIR and the on-site monitoring visit. ACF is currently developing a child outcome national reporting system which will be tested beginning this fall and implemented in FY 2004.	The HS PIR report presents aggregate data only.	9%	0.0
Total Section Score				**100%**	**55%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)					
1 *Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	no	Program goals call for maintaining gains in literacy, numeracy, language skills, social/emotional well being.	Data from FACES study.	20%	0.0

Long-Term Goal I:	Enhance children's growth and development through improved literacy, numeracy and language skills.
Target:	Children obtain a 34% percent gain in word knowledge
Actual Progress achieved toward goal:	32% increase
Long-Term Goal II:	Strengthen Families
Target:	70% of parents report reading to their child three times a week or more
Actual Progress achieved toward goal:	69% of parents report reading to their child three times a week or more
Long-Term Goal III:	programs provide developmentally appropriate educational developments -- increase degreed teachers
Target:	100% of teachers have an appropriate degree.
Actual Progress achieved toward goal:	86% of teachers had an appropriate degree

2 *Does the program (including program partners) achieve its annual performance goals?*	no	Annual targets call for maintaining gains in literacy, numeracy, language skills, social/emotional well being.	Data from FACES study.	20%	0.0

Key Goal I:	Children obtain a 32% percent gain in word knowledge
Performance Target:	32% increase
Actual Performance:	32% increase

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Key Goal II: Children obtain a 43% gain in mathematical skills Performance Target: 43% Increase Actual Performance: 43% Increase					
	Key Goal III: Children achieve a 43% gain in fine motor skills. Performance Target: 43% increase Actual Performance: 34% increase					
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	no	Head Start performance targets do not include efficiency measures. Several provisions of Head Start authorizing legislation require unit costs to rise on an annual basis and are beyond the control of ACF	Legal requirements to pay COLAs and set aside funds for quality increases raise the unit costs of providing Head Start services.	20%	0.0
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	large extent	HS classrooms rate higher than other pre-school programs using the Early Childhood Environment Rating Scale (ECERS) which measures a variety of processes in the classroom related to effectiveness	FACES found an average ECERS score of 4.9 in HS classes, which equates to good -- generally higher than the quality of other center-based preschool programs.	20%	0.1
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	large extent	Studies show that Head Start children grow in vocabulary, math and social skills while in the program and leave the program healthier and better able to learn than their socio-economic peers who did not attend Head Start.	ACF is conducting a nationally representative study of how HS affects the school readiness of participating children compared to children not enrolled in HS.	20%	0.1
Total Section Score					**100%**	**27%**

OMB Program Assessment Rating Tool (PART)

Competitve Grant Programs

Name of Program: Health Alert Network (HAN)

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The purpose of HAN is to create a communication, information and training system supporting an early warning and response network against bioterrorism and other public health threats, protecting the health of every American community. This has been established in authorization and appropriations law.	(1) "Vision, Goal and Core Components of the Health Alert Network" - Nov. 17, 1998 (2) Sec. 103 of PL 107-188 (3) Senate Report 107-216.	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The need for HAN was identified in studies by NACCHO in 1996 and 1998. In 1999, CDC and NACCHO conducted tests demonstrating that there were major gaps in the capacity to communicate reliably and swiftly with state and local public health departments in the event of a public health emergency. This need is further underscored by the events of the fall of 2001. NACCHO updated their findings by conducting another survey in October of 2001.	1) 1996 Study of Electronic Communication Capacity of Local Health Departments; 2) Profile of Local Health Department Capacity to Respond to Bioterrorism Incidents, March 26, 1999; 3) Report and Recommendations to the Appropriations Committee, US Senate: Strengthening Community Health Protection Through Technology and Training -- The Health Alert Network, 9/98 (4) Assesssment of Local Bioterrorism and Emergency Preparedness, 10/01	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	Federal leadership is appropriate in this effort, including: establishing system standards; developing and disseminating information for improving public health practice, and coordinating information flow and directing the emergency response to a national public health threat such as a bioterrorist attack. HAN is designed to take advantage of Federal capacities, but to exist as a network between state and local health agencies, as well as CDC at the Federal level. This maximizes coordination, and information flow from and among state and local partners, rather than exclusively from CDC.	There are several examples of state and local investments to participate in the Federal HAN, and in some cases, create their own state-wide HAN.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	No other federal agency or private organization provides this capability or assistance. CDC has established partnerships with national public health organizations, other Federal agencies such as the Office of Domestic Preparedness at DOJ, FEMA and other HHS agencies (FDA, HRSA, NIH). No GAO report on HAN has identified redundancy or duplication of effort. State and local public health agencies have been working closely with CDC to establish and maintain the HAN, and have used it to increase their capacity, not duplicate existing capacities.	(1) June 2002 list of National Professional Associations on the Primary Direct Transmission List (n=67) (2) several state HAN websites, including: http://www.state.de.us/dhss/dph/han/index.html ; http://www.state.nj.us/health/lh/lincs/bioman.htm ; and http://www.state.vt.us/health/han/pubhan.htm	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The cooperative agreement defines grantee expectations, prohibits supplantation, defines CDC's role, requires collaboration, and has a short enough duration to allow for changes as research and experience suggest changes are needed.	"Guidance for FY 2002 Supplemental Funds for Public Health Preparedness and Response for Bioterrorism" (Announcement 99051) February 15, 2002	20%	0.2
Total Section Score					**100%**	**100%**

Section II: Strategic Planning (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes		See three goals listed in question I, section IV	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes		See three goals listed in question 2, section IV	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	No	Grantees regularly provide a great deal of useful information specified in the cooperative agreement. This information has supported the goals as established to this point. To the extent that CDC/HAN has agreed to slightly adjusted goals for the future, grantees have not yet committed to these goals as of yet.		14%	0.0
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	HAN has worked since its inception with related efforts including the National Electronic Disease Surveillance System (NEDSS) and Epi-X. The information technology requirements and standards for HAN are identical to those for NEDSS and Epi-X. In addition, HAN staff are working with FEMA to develop compatible HF Radio capacity to establish redundant communications for emergency situations when primary lines may be disabled or overloaded. Lastly, in FY 2002 HAN was included among a variety of HHS bioterrorism state preparedness grant processes that were announced, reviewed and released concurrently to facilitate improved state planning and avoid duplication of effort.	(1) Public Health Information Technology Functions and Specifications (for Emergency Preparedness and Bioterrorism) - February 8, 2002 -- available at: www.bt.cdc.gov/planning/CoopAgreementAward/CDC9ITFunctionsandSpecifications (2) for collaboration between NEDDS and HAN, see "NEDDS and HAN - March 18, 2002 (3) Testimony of Edward Baker, MD before the House Subcommittee on Technology and Procurement Policy - "Bioterrorism Preparedness: CDC Efforts to Improve Health Information at Federal, State and Local Levels" (4) HHS announcement of state and local bioterrorism preparedness grants, found at: http://www.hhs.gov/news/press/2002pres/20020131b.html	14%	0.1
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	CDC hired the Center for Naval Analysis to conduct an evaluation of HAN which was released in 2002. This evaluation made recommendations about the structure and future role of HAN. CDC plans to conduct evaluations of HAN program management every three years.	"Observations and Analysis of Health Alert Network" - Center for Naval Analysis, 2002. (Stewart, Speers, and Hughes)	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	Yes	Budget and program are aligned in such a way that the recent influx of emergency funding has resulted in a significant acceleration of targets for HAN performance goals.	For example, 100% connectivity was initially estimated by FY 2004, delayed, and now revised for achievement by FY 2005.	14%	0.1
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	Now that CDC/HAN goals have been adjusted, they will work closely with grantees and partners to assure that reporting is closely tailored to these new measures. CDC/HAN has a history of doing so successfully with previous measures.		14%	0.1
Total Section Score					**100%**	**86%**

Section III: Program Management (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	HAN grantees must report semi-annually on progress in developing critical capacities and achieving benchmarks. HAN technical officers conduct site visits, monthly conference calls, and an annual training conference. Grantee data is maintained in a database that tracks progress and can be used to adjust goals, and make future budget decisions based on current progress.	(1) Guidance for Fiscal Year 2002 Supplemental Funds for Public Health Preparedness and Response for Bioterrorism (Announcement #99051) February 15, 2002 (2) Guide for Conducting Technical Site Visits for Budget Period 8/31/2001 through 8/30/2003	11%	0.1
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	CDC Senior Executive Service (SES) managers have performance contracts which include program-specific goals. PHPPO leaders hold program managers accountable for a set of top priority goals they report on throughout the year.	CDC/ATSDR Senior Executive Service Performance Plan for Appraisal Period 10/01/01 - 9/30/02	11%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	No	Documentation has been provided to indicate that CDC monitors state expenditures of funds for purpose, but no documentation has yet been provided to demonstrate timeliness.	"FY 2002 Spending Plan Guidance" document to grantees, April 13, 2001 (2) PHPPO Program Funding for 99051 - Focus Area E, 3 Year Funding History	11%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	To improve cost effectiveness, CDC opted to adopt industry-standard architecture over federally developed specifications, the internet over a dedicated federal system, and commerical, off-the-shelf software over specifically designed programming. In addition, HAN was designed to be interoperable with other IT systems in order to maxmize its use and impact.	Public Health Information Technology Functions and Specifications (for Emergency Preparedness and Bioterrorism) - February 8, 2002 -- available at: www.bt.cdc.gov/planning/CoopAgreementAward/CDC9ITFunctionsandSpecifications	11%	0.1
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	Yes	CDC includes the full costs (including administrative) in its program activity lines. In addition, HAN has demonstrated that program performance can be identified with changes in funding levels. Initial goals were made less ambitious when less funding than requested was attained, and have been restored to a timeframe similar to their initial goals based upon the major influx of funds provided in the FY 2002 ERF, and requested in the FY 2003 Budget.	(1) PHPPO FY 2002 Indirect Cost Allocation Table (2) CDC-HAN GPRA goals and internal benchmarks - FY 1999 through FY 2003	11%	0.1
6	*Does the program use strong financial management practices?*	No	The HHS Financial Statement Audit cited two reportable conditions regarding the manual nature of CDC's accounting processes, although it did not find any internal material weaknesses. Until the HHS-wide Unified Financial Management System is in place, CDC will not be able to fully automate its financial accounting practices. However, CDC has generally made improvements to its financial management processes over the past few years, including restructing its budget and financial accounting system to more accurately track CDC's expenditures and hiring a consulting firm to develop a more consistent and accurate system for charging overhead.	The HHS Financial Statement Audit cites no material weaknesses, but two reportable conditions: (a) Financial statements had to be prepared manually to ensure accuracy; (b) CDC had to undertake a cumbersome process to reconcile its reimbursable agreements at the end of the year.	11%	0.0
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	(1) PHPPO employs two accountants to ensure that payments are properly posted and accounts are properly charged. One accountant works in a branch of PHPPO outside the one that manages HAN, so as to independently review HAN financial information without any conflict with program staff. (2) Also, HAN staff have revised their emergency operations plan, which was one deficiency indentified in the CNA evaluation.		11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
8 (Co 1.)	*Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?*	Yes	All CDC grants are reviewed by multiple objective review teams and technical experts. In the case of HAN, grant amounts are based on population, however the review panel can recommend modifications.	Such modifications have happened on a number of occassions, including most recently, where DC received double what they would based only on population, due to its strategic location.	11%	0.1
9 (Co 2.)	*Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	N/A	At this point, all states are HAN grantees, and there are no eligible new/first time grantees.		0%	
10 (Co 3.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	HAN grantees report semi-annually on progress in developing critical capacities and achieving benchmarks. HAN technical officers conduct site visits, monthly conference calls, and an annual training conference. Grantee data is maintained in a database that tracks progress toward critical capacities, key contacts, budget and other grantee information.	(1) Guidance for Fiscal Year 2002 Supplemental Funds for Public Health Preparedness and Response for Bioterrorism (Announcement #99051) February 15, 2002 (2) Guide for Conducting Technical Site Visits for Budget Period 8/31/2001 through 8/30/2003	11%	0.1
11 (Co 4.)	*Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	N/A	HAN staff had initially planned to display state/regional specific progress information on-line. However, it has been determined by CDC/HHS that such information, if available publicly, could be used to target more vulnerable areas, or learn the vulnerabilities of designated intended targets.		0%	
Total Section Score					**100%**	**78%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)						
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Small Extent		CDC has just reconfigured their long term goals to be more outcome oriented. Therefore, their progress has not been measured thus far against these targets. However, some progress has been made against previous output targets, which built the framework for these new goals and targets, and future accomplishments.	20%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Long-Term Goal I:	Build, operate, and maintain a nationwide electronic platform for information, communication, and training linking local, state, and Federal public health agencies.				
	Target:	BY 2005, establish and maintain three capacities at all State and Local public health jurisdictions: (1) high speed, continuous internet connectivity; (2) 24/7 broadcast capability to local public health officials and key community partners; and (3) distance learning infrastructure capable of delivering Satellite or web-base programs to front-line practicioners -- all according to CDC established technical standards.				
	Actual Progress achieved toward goal:	68% of population covered in FY 2002.				
	Long-Term Goal II:	Enhance and maintain the skills and essential competencies of the public health workforce to perform the essential services of public health on a routine and emergency basis through distance-based training and education.				
	Target:	By 2007, ensure that the public health workforce is: trained and certified in the core and discipline-specific competencies for terrorism preparedness and response, and the deployment and use of the HAN and Distance-Learning Infrastructure; and has access to distance-based training and education to meet continuing education requirements necessary for professional accreditation and licensing.				
	Actual Progress achieved toward goal:	In FY 2002, a network of public health evaluators established in Centers for Public Health Preparedness (CPHPs) has been built, and 30% of HAN grantees has a relationship with one or more CPHP.				
	Long-Term Goal III:	Validate the rapid exchange of urgent health alerts through regular network testing.				
	Target:	By 2007, senior state public health agencies will acknowledge receipt of Health Alert messages within 30 minutes of transmission and local health agencies will acknowledge within one hour of transmission on a 24/7 basis.				
	Actual Progress achieved toward goal:	Establishing baseline				
2	*Does the program (including program partners) achieve its annual performance goals?*	Large Extent		CDC has just reconfigured these goals to be more outcome oriented. Therefore, their progress has not been measured thus far against these targets. However, good progress has been made against previous output targets - exceeding them in many cases. This progress built the framework for these new goals and targets.	20%	0.1
	Key Goal I:	Establish and maintain three capacities at all State and Local public health jurisdictions: (1) high speed, continuous internet connectivity; (2) 24/7 broadcast capability to local public health officials and key community partners; and (3) distance learning infrastructure capable of delivering Satellite or web-base programs to front-line practicioners -- all according to CDC established technical standards.				
	Performance Target:	Extend all three capacities to cover 90% of the population by FY 2003, 95% by FY 2004, and 100% by FY 2005.				
	Actual Performance:	Funding provided to all 55 grantees in FY 2001, 68% of counties fully connected to HAN by FY 2002.				
	Key Goal II:	Ensure that the entire public health workforce has access to training and distance based learning programs implemented or supported by CDC, including the Centers for Public Health Preparedness (CPHP).				
	Performance Target:	BY 2006, ensure all grantees are served by a CPHP and hold all CDC required certifications. By 2005, 90% served and 40% certified. By 2004, 80% served and 25% certified. By 2003, 50% served and 10% certified.				
	Actual Performance:	In FY 2002, a network of public health evaluators established in Centers for Public Health Preparedness (CPHPs) has been built, and 30% of HAN grantees has a relationship with one or more CPHP. In FY 2001, 4 centers had been established, with 202,000 public health professionals participating in distance learning activities (compared to '01 target of 120,000).				

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Key Goal III:	Validate the rapid exchange of urgent health alerts through regular network testing.				
	Performance Target:	By 2004, CDC will be able to transmit health alerts to all of the nation's state and local public health agencies on a 24/7 basis, within 30 minutes of notification that an alert must be trasmitted. [State: 100% in 2002; Local: 60% in 2002, 80% in 2003] By 2006, all state public health agencies will be able to broadcast Health Alerts within 1 hour of notification that an alert must be transmitted on 24/7 basis. By 2007, state public health agencies will acknowledge receipt of Health Alert messages within 30 minutes of transmission and local health agencies will acknowledge within one hour of transmission on a 24/7 basis. [State: Baseline in 2003, 60% in 2004, 80% in 2005, and 90% in 2006; Local: Baseline in 2003, 25% in 2004, 50% in 2005, and 75% in 2006]			
	Actual Performance:	Alerts can now be transmitted to 100% of states and 60% of local public health agencies.				
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Small Extent	Efficiency gains have been seen in reports from grantees, including leveraging alternative resources, using federal dollars to desig systems for dual or multiple use, integrating HAN with other initiatives, reaching previously unreachable communities, and exceeding a number of annual targets.	(1) Centers for Public Health Preparedness: Leading the Way in Building Response Capacity for Local Public Health July 2000 and Local Centers for Public Health Preparedness: Models for Strengthening Public Health Capacity August 2001 - 2000 and 2001 NACCHO reports on Local Centers for Public Health Preparedness (2) August 30, 2002 letter from Florida Health Dept on Impact of HAN (3) Similar correspondence/reporting from CT, MN, MT, TX, GA, CO, RI, and KS	20%	0.1
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Small Extent	It is too early to claim a fully favorable comparison for this relatively new effort. However, indications about progress made thus far are positive.		20%	0.1
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Small Extent	No GAO study that includes HAN has criticized it. The only major evaluation of HAN (by the Center for Naval Analysis) indicates some successes, particularly during the fall of 2001. However, it focuses on future gains to public health preparedness through some fine-tuning of HAN, and includes recommendations for an expanded role in the future. In sum, so far so good, but the bulk of the results (which evaluators seem to expect will be positive) are yet to be demonstrated.		20%	0.1
Total Section Score					**100%**	**40%**

OMB Program Assessment Rating Tool (PART)

Direct Federal Programs

Name of Program: Health Care Fraud and Abuse Control (HCFAC)

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The purpose of the Health Care Fraud and Abuse Control Program (HCFAC) is clear. The program is designed to prevent health care fraud, waste and abuse. While the statute broadly defines health care fraud to cover fraud in all health care programs, public and private, the Office of Inspector General's (OIG) role is limited to Medicare and Medicaid. However, as health care fraud often involves multiple programs, the OIG's efforts frequently benefit programs other than Medicare and Medicaid.	See statement of program purpose and goals in section 1128C of the Social Security Act. 42 U.S.C. 1320a-7c. Specifically, the statute requires that the Attorney General, and the HHS Secretary acting through the Department's Office of the Inspector General (OIG) establish a program (1) to coordinate Federal, state and local law enforcement efforts relating to health care fraud and abuse; (2) to conduct investigations, audits and evaluations relating to the delivery of and payment for health care; (3) to facilitate enforcement of all applicable remedies for such fraud; (4) to provide formal guidance to the health care industry regarding fraudulent practices; and (5) to establish a national data bank of final adverse actions against providers. The statute further specifies that the OIG focus their activities on Medicare and Medicaid.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program address a specific interest, problem or need?*	Yes	The primary problem HCFAC addresses is health care fraud, waste, and abuse. The HIPAA statute created the HCFAC program in 1996, at which time the FBI reported that vulnerabilities to fraud existed throughout the entire health care system, and the DOJ reported that fraud was being perpetrated not only by physicians, but also by public corporations, labs, hospitals, nursing homes, and other entities. An additional problem HCFAC addresses is the flagging solvency of the Medicare Trust Fund. The HCFAC program reduces fraud that drives up health care costs and also returns funds collected from health care enforcement activities directly to the trust fund.	In 1996, GAO estimated that health care fraud cost the industry between $30 and $100 billion. The OIG estimated the Medicare error rate at 14%, or $23.2 billion. The FY 2001 Medicare error rate, 6.3% or $12.1 billion, further indicates that the problem still exists. At the time HIPAA was passed, the Medicare Trustees predicted the program would be bankrupt by 2001. To address this solvency crises, HCFAC requires that funds collected as a result of health care enforcement be deposited to the HI trust fund even if the underlying case does not address Medicare (SSA section 1817(k)(2)(C)). Additionally, the statute requires the HHS Secretary and the AG to report annually to Congress on funds appropriated to and from the trust fund under HCFAC, and the GAO must audit these figures every two years. (SSA 1817 (k)(2)(C))	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The HCFAC program design is calculated to directly address the underlying problems of rising health car fraud. First, the statute mandates coordination among the OIG, FBI, and DoJ to plan, implement, and report on program activities. For example, the Secretary of HHS and the Attorney General have developed joint program guidelines and must annually agree on the level of resources to spend on various activities (subject to the statute's limitations). Secondly, the statute requires both enforcement and prevention activities and allows the agencies broad latitude on determining the best methods for reducing fraud, waste, and abuse rather than mandating discreet tasks in law. Finally, by requiring that all proceeds be deposited in the Medicare Trust Funds .	Section 1128C of Social Security Act outlines the broad authorities given to HHS and DOJ to fight health care fraud and abuse.(see question #1 above). Additionally, it stipulates that "The Managing Trustee shall transfer to the Trust Fund..an amount equal to criminal fines..civil monetary penalties and assessments.. amounts resulting from forfeiture of property..and penalties and damage..due to the resolution of health care fraud and abuse cases. Evidence also includes the annual funding agreement between the HHS Secretary and AG	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	There are a number of factors that make HCFAC's contributions unique. First, there is no other specific Federal program outside of HCFAC whose purpose is to reduce health care fraud, waste, and abuse. Second, the statute mandates the coordination of all Federal, State and local law enforcement programs to ensure that the various law enforcement entities coordinate efforts and are not needlessly duplicating activities. This effort to coordinate activities is appropriately centered at the national level. Finally, since law enforcement in inherently a governmental function, the program doe snot duplicate private sector activities.	Section 1128C of Social Security Act which requires coordination of Federal, State, and local law enforcement activities. Health Care Fraud and Abuse Control Program and Guidelines, January 1, 1997, which more specifically addresses coordination and cooperation between various participants.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The HCFAC program supports the major components of a successful anti-fraud program, including prevention, audits and investigations, prosecution, and monetary and other penalties (e.g., disallowances). OIG activities are inherently governmental and there is no evidence to suggest an alternative program mechanism would be more effective. HCFAC activities are funded through direct spending authority, with funding fixed in statute. This is one element of the program's design that is not optimal because it does not allow for an annual review of funding for health care anti-fraud activities. The agencies contend that having dedicated, mandatory HCFAC resources is an essential component of the program's design. However, there is no evidence to suggest that HCFAC could not be equally successful if these activities were discretionary. Moreover, the inherent annual review and evaluation of the discretionary process could improve a program whose success, or lack thereof, has no impact on its budget currently.	There is no evidence to suggest an alternative program mechanism would be more effective.	20%	0.2
Total Section Score					**100%**	**100%**

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning	**(Yes,No, N/A)**				
1 *Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	No	To date, the OIG has used return on investment (ROI) figures as performance measures. The measure calculated the ROI of (1) expected recoveries from investigative receivables and audit disallowances and (2) savings from funds not expended as a result of audits, investigations and inspections. As part of the PART discussion, it is now proposing three additional long-term goals. For its FY 2004 GPRA, the OIG is now proposing four HCFAC goals: expected recoveries, including judgements, settlements, and administrative actions; savings, or funds not expended as a result of OIG finding and recommendations; return of investment (ROI), or recoveries and savings for each dollar invested in OIG HCFAC activities; and the Medicare payment error rate. While these goals do provide some information on the status of fraud and abuse activities, they do not meet the PART standards for long-term performance goals for the following reasons (the OIG's response to these concerns is outlined in the evidence section:	The OIG proposed four goals: (1) Expected recoveries: FY 2004 target of $1,240 million (2) Savings: FY 2004 target of $23,700 million (3) ROI: FY 2004 target of $156:$1 (4) Medicare Error Rate: FY 2004 target TBD by CMS	17%	0.0
		<u>Overall concerns</u>. The core purpose of HCFAC is to reduce or eliminate health care fraud and abuse. As such, one overall measure of the program should reflect progess towards this core purpose. For example, an estimate of fraud and abuse, such as a fraud rate, and progress at reducing it would an effective long-term goal for HCFAC. Although measuring fraud is very difficult, it is important to provide information on HCFAC's performance against its key goal. If something similar to a fraud rate cannot be developed, than a proxy should be used. A measure of the type outlined above would also provide the OIG with a baseline against which to measure progress. The goals proposed by the OIG do not have baselines, which makes it difficult to interpret the results. For example, an increase in expected recoveries could indicate on e of three things (1) a positive outcome - that the OIG is successfully resolving health care disputes, (2) a negative outcome - that fraud is increasing and there is thus more fraud to catch or (3) a combination.	None of the OIGs targets (other than the Medicare Error Rate) are set against a baseline (such as expected recoveries out of total possible recoveries). The OIG objects to the development of a fraud rate or a baseline for expected recoveries and savings for the same general reasons. The OIG believes that a fraud estimate cannot be prospective - actual fraud occurs only when it has been legally adjudicated, and as such, as fraud rate would require enormous resources to pursue every potentially fraudulent item. Many industry experts agree. However, other entities, such as the GAO, believe it is possible to develop an estimate of health care fraud.		

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
		(2) Expected Recoveries. Other than preventing fraud, another goal of the HCFAC program is to restore funds to the Medicare trust funds. For this goal, a measure similar to the OIG's expected recoveries goal could be suitable. However, expected recoveries do not translate into actual collections or deposits to the trust fund. Actual deposits to the trust fund for 1997-2000 were approximately 50% of expected recoveries. For this reason, actual recoveries may be a more informative measure.	Expected recoveries for 1997-2000 = $3623 million (OIG FY 2004 draft GPRA plan). Of these, $2,502 million were collected to date (69%). After paying relators and other, $1,881 were deposited to the trust fund (52%) (Joint HHS and DOJ Annual Reports 1997-2000). Figures for FY2001 are not included because it is unlikely that collections for those activities would have begun. The OIG objects to the measurement of actual recoveries because collections are not in their control.		
		(3) Savings and ROI measures A large majority of the OIG savings (approximately 85% in FY2001) is due to savings from the BBA, passed in 1997. While the savings and ROI measures include savings due to reduced fraud, waste, and abuse, they also include significant savings due to many other factors, such as management decisions, industry trends in payment methodologies, etc. Additionally, these savings are attributable to many actors, such as the GAO,CMS and the OIG. This is not to say that the OIG didn't contribute to these savings, just that they cover too broad a range of issues and actors to be a good indicator of OIG performance. Additionally, although some lag time is expected between law enforcement activities and results, the savings attributable to legislation passed in 1997 may not be a good indicator of the OIG's current successes .	Savings are calculated by the OIG using CBO projections of the savings due to the passage of the Balanced Budget Amendment. Savings are attributed to the OIG upon implementation of the legislation, and thus are still being recognized by the OIG in FY 2001. Total savings due to OIG activities in FY 2001 was approximately $16,058 million (OIG FY 2004 draft GPRA plan), of which approximately $13,720 million were due to the implementation of the BBA (OIG semi-annual reports for FY 2001 and staff analysis)		
		Medicare Error Rate. The Medicare error rate measures improper fee-for-service payments. Due to the methodology used to calculate the error rate, it includes some, but not all, fraud. As such, the error rate is primarily focused on claims processing error, and is thus a good performance measure for CMS. Due to these limitations of the methodology, however, it is not a good measure of the OIGs contributions to reducing fraud, waste and abuse(although it could potentially be expanded or leveraged to help estimate abuse).	Medicare Error Rate: One of the main limitations to using the Medicare Error rate for fraud detection is its core methodology (which is appropriate for estimating improper payments but not fraud). It assumes that all claims received by contractors are for services that are actually provided. Thus, it does not detect completely fraudulent claims for services never delivered.		

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	No	The OIG has proposed annual targets for each of the long-term goals identified in #1 above. Though these annual goals could measure the program progress towards meeting the OIG's long-term goals, the long-term goals do not meet the PART standards and requirements. As referenced in the answer to Question 7, OMB and OIG will continue to discuss setting preliminary, annual performance goals (e.g., developing methodologies and/or baselines) for new long-term goals.		17%	0.0
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	N/A	Substantially all of the OIG's work is done by its federal agents. While the OIG does occasionally use contractors, they work directly in response to specifications provided by the OIG to complete very technical services and are not strategic partners.	Assessment made based on staffing processes followed by the OIG given the inherently governmental nature of their work.	0%	
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	One of the primary goals of HCFAC is to ensure coordination among the many Federal agencies that are involved in reducing health care fraud, waste, and abuse. OIG collaborates with similar programs in CMS, other HHS agencies, and the DoJ from the initial planning to the execution through the reporting of successful anti-fraud, waste, and abuse activities.	The Health Care Fraud and Abuse Control Program and Guidelines provides extensive documentation of coordination among Federal, State and local law enforcement efforts. Coordination is achieved chiefly through task forces at various levels, including the Executive Level Health Care Fraud Policy Group, the National Health Care Fraud Working Group, State and Local Health Care Fraud Task forces and the National Health Care Fraud Task Force.	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	No	Although the GAO conducts a statutorily-required biannual report of HCFAC activities, it focuses on ensuring the appropriateness of program expenditures and returns to the Trust Fund. As such, its scope is limited to auditing accounting transactions rather than assessing mission acheivement or recommending program improvements. The OIG is also subject to a peer review audit which reviews the organization's Office of Audit Services (one of three OIG offices) to ensure internal quality control systems are in place. However, this audit is also limited in scope as it reviews only OIG audit activities and focuses on quality control rather than program performance or achievement of mission. The Office of Investigations has an internal peer review, and is participating in a President's Council on Integrity and Efficiency (PCIE) intitiative which will institute peer reviews of OIG Offices of Investigation. However, that initiative has not yet been launched. To date, no external entity assesses the OIG's program management activities or performance against the goal of reducin fraud.	Assessment includes a review of GAO-02-731 "Health Care Fraud and Abuse Control Program for Fiscal Year 2000 and 2001," and PCIE Guides conducting reviews.	17%	0.0
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	Total funding for OIG HCFAC activities is set in statute. In the aggregate, there is no alignment between budget, policy and legislative changes and program performance. Below the top line total, the OIG does not have a long-term performance goal that measures progress at eliminating fraud and abuse (see question #1) or that quantititatively breaks down the areas (e.g. home helath, DME, etc.) with the highest levels of fraud and abuse. It is thus difficult for the OIG to demonstrate integration of performance with budget decisions. When examining the question in relation to the OIGs goals (expected recoveries, savings, ROI and Medicare error rate), there is some evidience that these goals help influence budget decisions. However, it is unclear how failure to reach these goals, or a change in these goals, would impact resourcing decisions. It is also important to note that there is not a tight connection between the OIG's current goals and its resourcing decisions in part by design. (con't)	The HCFAC statute stipulates the OIG's budget. The FY 2004 budget is set at between $150-$160 million. Below the aggregate amount, the OIG resources are divided between the Office of Audit Services, the Office of Evaluations and Inspections, and the Office of Investigations. Each of these offices has their own work prioritization process. The OIG states that decisions are driven in part by the goals of reducing Medicare improper payments, maximizing recoveries to the trust funds, and preventing unnecessary expenditures. However, it is unclear how the different risk assessment methodologies, probes, pilots and other prioritization methods link the budget with attaining performance goals.	17%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
			Because of the nature of its goals, the OIG does not want to appear to set monetary or investigational goals for selected activities, which could be perceived as bounty hunting. Additionally, some of OIG activities are reactionary and unpredictable, such as special requests from stakeholders and Congress and emerging threats or vulnerabilities, which limits OIG's ability to integrate budget and performance completely in the program's strategic planning process.			
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	No	OMB and OIG conducted extensive discussions on the development of new measures. Proposals discussed included developing new measures such as a fraud rate, further exploiting current measure such as the error rate to dive out mistakes from abuses, and the development of baselines for existing measures such as expected recoveries or savings. However, as discussed in question #1 , the OIG strongly objects to the feasibility of developing a fraud rate or other baseline measure of the amount of fraud and abuse.	The OIG believes that a fraud estimate cannot be prospective - actual fraud occurs only when it has been legally adjudicated, and as such, as fraud rate would require enormous resources to pursue every potentially fraudulent item. Many industry experts agree. However, other entities, such as the GAO, believe it is possible to develop an estimate of health care fraud.	17%	0.0
Total Section Score					**100%**	**17%**
Section III: Program Management (Yes,No, N/A)						
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	The statute requires the annual collection and reporting of performance data annually from the AG and Secretary. These reports contain data on program expenditures, recoveries, and goals and accomplishments of agencies funded through HCFAC. OIG also collects additional information on program processes and outputs to help manage the program.	The HCFAC Annual Reports outline data on program expenditures, recoveries, goals and accomplishments. Additionally, the OIG tracks and uses process and output measures, such as # of advisory opinions issued, exclusions from Medicare and other Federal health programs, administrative sanctions; program exclusions; criminal convictions, etc..	17%	0.2
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	OIG managers are held accountable to the broad performance goals outlined in the agency's GPRA plan. These goals are incorporated into the performance contracts with senior OIG managers. The OIG believes that tying specific outcomes (e.g., monetary penalties and criminal sanctions) to performance management is problematic and would be tantamount to a 'bounty' system. The OIG has a very limited number of "partners," such as subcontractors, that participate in HCFAC-funded activities.	Assessment based on OIG Personnel Evaluations	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	OIG tracks the obligation of HCFAC resources on a monthly basis and ensures that only HCFAC resources (and no other OIG resources) are spent on health care fraud, waste, and abuse. The statute requires that GAO review the HCFAC program biennially and submit its report to Congress. The most recent report indicates that "HHS expenditures "were generally appropriate."	GAO June 2002 Report "Medicare: Health Care Fraud and Abuse Control Programs"	17%	0.2
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	The OIG has only a limited number of process measures for efficiency, such as completing 80 percent of all audits within one year or less and requiring its Medicare Fraud Hotline contractor to meet customer service goals for Hotline calls. Additionally, the OIG does calculate an ROI measure. However, for the reasons discussed above, the limitations of the ROI measure as currently calculated make it less useful as a measure of efficiency or cost effectiveness .	Assessment based on OIG GPRA Plan. Note that most of OIG's HCFAC activities (e.g., law enforcement) are inherently governmental so competitive sourcing and cost comparisons do not apply.	17%	0.0
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	N/A	The budget for OIG activities under HCFAC is fixed in statute. Therefore, performance has no impact on OIG's HCFAC activities. However, OIG does track HCFAC resources carefully to ensure that anti-fraud activities in the Medicare and Medicaid programs are supported only through HCFAC funds.		0%	
6	*Does the program use strong financial management practices?*	Yes	An independent audit of OIG's HCFAC activities performed by GAO has certified in each of the three biennial reports that the financial management practices are free from material weaknesses.	GAO Reports for FYs 2001 and 2000, FYs 1999 and 1998, and FY 1997.	17%	0.2
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	The OIG HCFAC program has not been cited for management deficiencies. However, OIG has accepted recommendations for program management improvements from GAO and other similar entities in the past. For example, the June 2002 GAO recommended that the OIG assess the feasibility of tracking savings and expenditures by affected program; OIG has accepted this recommendation.		17%	0.2
Total Section Score					**100%**	**83%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section IV: Program Results		**(Yes, Large Extent, Small Extent, No)**				
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	No	As discussed in Section 2, question #1, the OIG does not have long-term goals that meet the requriements of the PART. As such, they are required to receive a 'no' for this quesiton. That being said, the OIG has had significant successes in helping to reduce fraud, waste and abuse. The OIG has realized substantial recoveries to the Trust Fund , and contributed to substantial program savings by identifying and recommending corrections to close loopholes or stop abusive billing practicies. For example, between 1997 and 2000, $1,881 million was deposited to the Medicare Trust Fund due to the combined efforts of the OIG, the FBI , CMS and the DOJ. Additioanlly, the Medicare Trustees have attributed the slowed groth in the Medicare baseline and improved Medicare solvency in part to "continuing efforts to combat fraud and abuse, and "changes made by the BBA of 1997." It is, however, difficult to tell what kind of an impact these success have had on the size of the problem of fraud and abuse without a measure that helps to define the problem.	See Section #2, question #1 above	25%	0.0

Long-Term Goal I:	
Target:	
Actual Progress achieved toward goal:	
Long-Term Goal II:	
Target:	
Actual Progress achieved toward goal:	
Long-Term Goal III:	
Target:	
Actual Progress achieved toward goal:	

2	*Does the program (including program partners) achieve its annual performance goals?*	No	As discussed in Section #2, question #2, the OIG's annual goals are incremental targets toward their long-term goals. As such, they do not meet the requirements of the PART. That being said, as mentioned above, the OIG has demonstrated significant success in reducing fraud, waste, and abuse. For example, in FY 2001, their were $1,624 million in expected recoveries and receivables. While not all of these funds will be collected or returned to the Trust Fund, a substantial portion should be.	See section #2, question #2 above.	25%	0.0

Key Goal I:	
Performance Target:	
Actual Performance:	

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Key Goal II: Performance Target: Actual Performance:					
	Key Goal III: Performance Target: Actual Performance:					
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Large Extent	Although it is unusual to have a no in section #3, question #4 coupled with a positive response to this question, it is warranted in this case. Although the OIG doesn't calculated an ROI of actual dollars returned to the trust fund vs. HCFAC costs, such a calculation reveals that the program returned $1,900 million to the Trust Funds from 1997-2000 vs. the OIG's budget for that period of $373 million. Thus, the program returned $5 for every $1 spent. (Although, as described in section #2, question #1, it is unclear due to the lack of a baseline whether this number represents a large or small percentage of the universe possible returns to the trust fund) The program would benefit, however, from developing other, more micro-focused efficiency measures to assist in program management.	Assessment derived from OIG GPRA plan, HCFAC Annual Reports issued by HHS and DOJ and staff analysis.	25%	0.2
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	N/A	The OIG is not part of the common measures exercise, nor are their relevant evaluations that allow comparison with other Federal Programs with similar purposes and goals.		0%	
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Small Extent	As discussed in Section #2, question #5, the OIG is not subject to independent evaluations of a broad scope. However, they are audited by the GAO on a biannual basis to ensure the appropriateness of program expenditures and returns to the Trust Fund. Each year of this audit, the GAO finds that "the planned use of HCFAC appropriations was in keeping with the stated purpose in HIPAA."	Assessment based on a review of GAO-02-731 "Health Care Fraud and Abuse Control Program for Fiscal Year 2000 and 2001" and prior year reports.	25%	0.1
Total Section Score					**100%**	**25%**

OMB Program Assessment Rating Tool (PART)

Competitive Grant Programs

Name of Program: Health Centers

Section I: Program Purpose & Design (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The purpose of the Consolidated Health Center program is clear. The program is designed to increase access to comprehensive primary and preventive health care and improve the health status of underserved and vulnerable populations. Health center grants support a variety of community-based public and private nonprofit organizations that provide required primary health services to a population in an area with a shortage of personal health services. Health Centers include a variety of organizations covered by the authorizing legislation, including organizations funded to serve migrant and seasonal agricultural workers, the homeless and residents of public housing.	The first Federally supported health centers were neighborhood health centers funded in 1965. The Health Centers Consolidation Act of 1996 authorized the current Consolidated Health Centers program (section 330 of the Public Health Service Act). The agency's program expectations are outlined in Policy Information Notice 1998-23. Agency regulations (42 CFR; Part 51c) specify the population to be served and the specific services to be provided. Agency and Congressional reports related to the program are consistent with the program purpose as outlined in the authorizing legislation. The program is run by the Health Resources and Services Administration (HRSA).	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The program seeks to address the problem of lack of access to quality health care. Major barriers to quality health care include poverty level, insurance status, geographic location, availability of physicians and other health care professionals, language and ethnicity. The program is designed to provide subsidized care to low-income individuals and those without health insurance. The program targets inner-city neighborhoods and rural communities where a lack of access to health care presents a significant barrier to improved health. The program also supports translation services for patients.	According to the 2000 Census, 39 million people are uninsured and 48 million people lack access to a primary and regular source of healthcare. Only 10% of all visits made to private practitioners are from uninsured patients. There are approximately 3-5 million migrant and seasonal farm workers in the United States and about 70% live below the poverty line. While estimates of the nation's homeless population vary greatly, there are approximately 600,000 homeless in the nation on a given night. Many inner city and rural populations have difficulty obtaining health services and have lower life expectancy and higher death rates compared to the overall population. Twenty seven percent of Health Center patients require translation services.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The program is designed to have a significant impact in underserved areas. The authorizing legislation and program regulations focus program efforts by requiring grant funding go to areas designed by the Federal government as medically underserved. The program provides funding, technical assistance, leadership, and quality assurance to health centers. In 1999, the Health Center grant provided $36 per encounter. The program also helps centers leverage other patient care revenue, including Medicaid, Medicare, and state, local and private funding. Health center costs also track closely with revenues, suggesting a significant impact of program funding to help offset the cost of uncompensated care. With respect to patient level impact, patient hospital visits and lengths of stay are reduced with primary care access. Early detection and screening also reduces morbidity and mortality.	In calendar year 2001, 748 Health Centers in 3,300 sites served 10.3 million people who would otherwise not have access to primary care clinicians. The program provides care to 10% of the nation's 39 million uninsured and 20% of the 48 million underserved in areas lacking access to primary care providers. Of those served, 88% are at or below 200% of poverty, 39% are uninsured, and 64% are persons of color. Translation services are provided at roughly 80% of Health Centers.	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	The bulk of evidence on this question indicates the program is designed to make a unique contribution. The program is unique in that it is designed to expand access to health care for underserved populations by providing revenue not tied to individual patients, and directly to organizations. While populations served by the program could seek care in emergency rooms, they are unlikely to get comprehensive and preventive care. The main beneficiaries of program resources are those without access to Medicaid, private health insurance, or other coverage. The program is also the only Federal health care subsidy available to non-elderly, low-income men. The Federal government does broaden access to health care through numerous mechanisms. In fact, health centers themselves receive revenue from a variety of sources, including Medicaid, Medicare, SCHIP, state, local, third party and self-pay collections, and other Federal programs such as Ryan White Title III, WIC, and the MCH block grant. There are also health centers that do not meet program requirements and are not funded by the program.	Health centers receive roughly 25% of their total funding from this program. An additional 41% of health center's funding comes from Medicaid (state and Federal combined), Medicare, SCHIP and other Federal grants. The remaining 33% comes from state, local, third party and self-pay collections. Health center revenues are 2% below costs. Eighty seven percent of Health Center patients are at or below 200% of poverty. The program serves 1.9 million males between ages of 20 and 64. The program also encourages quality improvement through specific initiatives and the use of the common data. The program authorizing legislation also requires grantees to demonstrate non-redundancy of the program contribution in their grant application to guard against supplantation of funds. The authorizing legislation requires the program fund grantees in underserved areas where populations are not being served by private providers and other programs.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The program provides grants to health centers that meet specified eligibility requirements. Care is not provided directly through Federal facilities. Federal grant funds supplement patient revenue from public and private insurance and out of pocket payments.	There is no evidence that a block grant or other mechanism would be more efficient or effective in addressing the problem.	20%	0.2
Total Section Score					**100%**	**100%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning		**(Yes, No, N/A)**				
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	The program's long-term goals focus on broadening access to health care, focusing services on the most vulnerable, and improving the quality of care. The program defines most vulnerable as low income populations and not just the uninsured. The first goal captures the President's initiative and is focused on expanding the reach of the program overall, while the second goal addresses targeting the most vulnerable within that overall expansion. The third goal emphasizes quality of care. The performance of health centers themselves is critical to the program achieving its overall goals, especially serving the most vulnerable and reducing low birth weight births. Low-birth weight is a useful outcome measure because it is an important clinical outcome of infant health and is a marker of the comprehensiveness and quality of services. Low-birth weight data are also useful because women of child-bearing age represent a key population targeted by the program and low-birth weight data are collected annually for all grantees.	Consistent with the President's initiative, the program's long-term expansion goal includes 1,200 new and expanded sites and 16.45 million people cared for annually by 2006. The program also includes as a long-term goal to reach 14.15 million low-income people in 2006, no less than 16% of the Nation's low-income population. As an indicator of improvements in clinical outcomes, the program has set as a long-term goal to have only 6.5% of all Health Center births be of low-birth weight in 2006. This goal builds on the 6% target for the nation overall adopted by Healthy People 2010. Data are provided through the Uniform Data System (UDS).	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	The program has adopted a limited number of annual performance goals that are discrete and measurable and demonstrate progress toward desired long-term outcomes. The program's annual goals are both output and outcome goals. The program is included in the Federal government's Health Common Measures and is also reporting on measures of cost, efficiency and quality. (For information on Common Measures, see www.whitehouse.gov/omb)	The annual goals mirror the long-term goals with intermediate annual targets. The program does measure additional outcomes in GPRA and through the UDS.	14%	0.1
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	The program's main goals focus on broadening access to health care, focusing services on the most vulnerable, and improving the quality of care. The program tracks additional measures using data from its UDS system, and reports on some of these data in their GPRA reports. With respect to the program's key goals highlighted here, program partners do support planning efforts by committing to the goals of the program. In some cases, the program ensures this commitment through explicit requirements in the grant and governing regulations. Other elements are encouraged in the program's authorizing legislation. Program grantees are required by statute to engage in strategic planning of their own, focused on increasing access and improving health status. Grantees commit to and report on performance in annual grant applications.	UDS data are obtained from roughly 748 of the 757 Federally supported health center grantees and include information about the center, services provided, client demographics, staffing, diagnoses, birth weight outcomes, financial costs, managed care, and revenues. Data on client outcomes are obtained using surveys of a sample of users and provider visits. A portion of Health Centers are involved in separate collaboratives on diabetes, depression and asthma. These centers provide client outcome data on care delivered in association with the collaborative, such as rate of diabetics receiving tests to measure average blood sugar levels. In instances where partners fail to contribute to the goals, the program provides additional oversight or technical assistance. Funding would only be discontinued if core requirements are ignored.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	No	Given the size and reach of the program, additional meaningful collaboration leading to changes in management and resource allocation is warranted. Health centers receive funding from multiple other agencies and funding and policy is not coordinated at the national level. The IG found in 1996 that nearly a third of homeless shelters do not refer the homeless to health centers for care. There is evidence of some collaboration. The program provides funding to primary care offices and primary care associations. The program is planning to jointly fund a $2.5 million grant with the Substance Abuse and Mental Health Services Administration on homelessness. In 1999, the program worked with HUD's Neighborhood Networks and was able to match 12 health centers with HUD networks. The school-based health centers program is working with EPA on six clinical chronic disease institutes to change clinical practice standards in school-based health centers for children with asthma. HHS is a member of the newly reopened Interagency Council on Homelessness.	The OIG found in 1998 that only 32% of Federally funded health centers are aware of treatment improvement protocols issued by HRSA's sister agency the Substance Abuse and Mental Health Services Administration. OIG concluded in 1998 HRSA could encourage better collaboration between health centers and state health departments. The program does work with the Centers for Medicare & Medicaid Services on reimbursement of services, the Agency for Healthcare Research and Quality on specific studies, and the Centers for Disease Control and Prevention on adult immunization, diabetes, asthma, and data collection. The program has also matched its Health Center User and Visit Surveys to mimic the CDC's National Health Interview Survey. The program has issued guidance to its field offices in recent years to expand local level collaboration and has continued an integrated services initiative to help health center networks link across providers and expand market share of Medicaid patients.	14%	0.0
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	The program collects data regularly on grantee performance and HHS conducts studies that help fill gaps in performance information. Comprehensive reports have also been provided by GAO. Research and journal articles on program performance are published periodically. HHS has used 1% evaluation funds to contract a series of evaluation studies on the program. Evaluations at the grantee level include the agency's own Health Center Primary Care Effectiveness Review (PCER). Since 1996, the program has also encouraged accreditation of health centers through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). GAO has suggested JCAHO reviews do not provide the most cost-effective oversight and OIG has cited limitations of other JCAHO reviews, but the program has found JCAHO helpful for confirming health center self-reports. The program's Uniform Data Set (UDS) data is available on an ongoing basis to provide program performance information to Federal managers and individual grantees.	GAO reported recently on the program's ability to respond to changes in the healthcare environment and other topics (HEHS-95-138/95-143/97-57/00-39/01-577). Examples of 1% evaluation studies since FY 1998 include the impact of SCHIP, linguistic services at health centers, the role of health centers in caring for low income adults with diabetes, care for hypertension, the impact of Medicaid waivers, and the experience of health centers under managed care. JCAHO surveyors validate grantee self-reported assessments of an agency provided survey tool (STAR). The PCER is a performance review tool used at the center level focused on compliance with legal, regulatory and program requirements and examines fiscal information beyond the reach of the JCAHO review. The PCER evaluation is typically conducted once during the grantee project period and the schedule is managed by the agency field office. UDS provides grantee level data on user demographics, services, staffing, productivity, utilization, costs and revenues, managed care, and clinical outcomes.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	Yes	The program can estimate the associated cost of outputs (number of sites and persons served), which is directly associated with the program's outcome goals. While the program's annual budget display does not meet all standards of alignment, the program's ability to attribute cost to each output is sufficient to meet the standards of this question. Program budget formulation is being driven by the cost of meeting specific long-term output goals associated with the President's initiative. The program also knows the average cost of a package of services at the grantee level and the advantages of that package with respect to clinical outcomes. Program management funds are budgeted elsewhere.	This assessment is based on the annual budget submission to OMB and the Congress, and other information provided by the agency. The initiative has set performance targets of an additional 1,200 new and expanded sites and an additional 6.1 million persons served by 2006. Annual budget requests are developed by estimating what is needed to accomplish these long-term goals over the five year period.	14%	0.1
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	The main deficiency had been that the program did not have discrete and measurable long-term goals outside of the growth initiative. The program has adopted quality long-term goals. In addition, the program updates its strategic plan regularly in response to organizational and legislative changes, changes in program priorities, and deficiencies in meeting plan objectives. The main deficiency highlighted in this section relates to collaborating with other Federal programs. The program is working with other Federal programs, especially those with responsibilities over funding streams that often benefit health centers, such as CMS and the HIV AIDS Bureau at HRSA. Additional areas of improvement for collaboration could include work with the National Institutes of Health and the Substance Abuse and Mental Health Services Administration to disseminate findings in mental health and substance abuse more quickly in clinical practice. The agency is working to tie budget planning to strategic planning.	The program developed a draft strategic plan. Managers are charged with monitoring progress and assuring alignment of program activities with the goals and objectives of that strategic plan. The program uses JCAHO reviews and its own PCER and STAR procedures for quality improvement at the grantee level. The program has also developed the Integrated Service Delivery Initiative (ISDI) to encourage grantees to work with other safety net providers in their community.	14%	0.1
Total Section Score					**100%**	**86%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section III: Program Management (Yes, No, N/A)						
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	The program collects information from health center grantees annually through the UDS. Federal program managers and individual grantees can use UDS data to compare center demographics, financial status, and performance with other centers in the state, other rural or urban centers nationally, and all centers nationally. GAO reported weaknesses in the UDS system in 2000. The program expects the conversion to electronic submission to address those concerns. Annual A-133 audits provide additional financial information on individual grantees. The Primary Care Effectiveness Reviews provide additional information. Centers participating in specific collaborative efforts provide additional clinical data. Performance data are used to assess overall trends to determine if management decisions are needed.	The UDS is a data collection system that tracks a variety of information grantees can use to improve care including user demographics, services provided, staffing ratios and productivity, utilization rates, costs and revenues, managed care penetration, and clinical outcomes. UDS, PCERs and financial reports provide the program with information on specific health centers that are in need of technical assistance. Program managers use the information to make decisions about continued funding, grant conditions, and corrective actions or improvements. Specific steps that are taken include shortened project periods, the placement of special conditions, and a requirement of recovery plans for grantees with performance issues. All health centers must have a quality improvement system that includes both clinical services and management.	9%	0.1
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The agency's senior managers are held accountable for operations of their programs, including performance results, through their annual performance contracts. This practice is new and no evidence is yet available on steps taken for poor program performance. Performance data are not taken into account routinely in program staff evaluations. The program requires that grantees set performance targets and report on performance and other data through the UDS and collaborative initiatives. The program contracts out site visits to deal with critical management concerns at individual centers. Based on these visits, contractors may recommend actions to field staff such as drawdown restrictions on grant funds and requiring action plans to address concerns. Grantees typically fail to have grants renewed because of poor financial performance, rather than failures to meet goals related to patient outcomes. Performance information could be extended to program staff performance evaluations or contracts.	The program takes extensive efforts to collect performance data for program grantees. Action is typically taken based on management issues. The program does not take action for low performance of grantees related to quality of patient care.	9%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	The program obligates funds in a timely manner. Award recipients undergo annual audits and report on planned and actual expenditures. Grantees provide a cash transaction report indicating the drawdown of funds and balances on a quarterly basis. Project scopes are monitored for compliance with program regulations. The program requires grantees to produce a Financial Status Report (FSR) and reconcile audits required under Federal law with the FSR.	Assessment based on apportionment requests; annual budget submissions and financial reports, queries in Single Audit Database, agency grants management procedures, and annual distribution of funds report.	9%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	There is evidence that the program has management procedures in place to ensure the most efficient use of each dollar spent on program execution. The program has maintained level Federal FTE totals during an extended period of program budget growth through improvements in the efficiency of Federal program execution. Specific examples of procedures already in place include outsourced activities to the Program Support Center and contracted technical assistance, management information system, logistical support, objective review committees, UDS data collection, and Federal Tort Claims Act (FTCA) risk management services. Through the Federal government's Health Common Measures, the program now also has an annual efficiency measure of clinical appointments per FTE for outpatient visits and tracks the total combined cost from all revenues per patient user.	The program is using the Management Assistance Corporation for site visit technical assistance and program improvement. The program outsourced contractual monitoring and payment to the Program Support Center. The program provides UDS data to grantees to compare their operations with other centers in the state and nation to encourage efficiency. Program staff have been maintained at no more than 20 FTE over a period of rapid budget growth in the program. The ISDI initiative is designed to help centers integrate activities and improve their efficiency by shifting tertiary management to primary and preventive care.	9%	0.1
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program does not have a financial management system that fully allocates program costs and associates those costs with specific performance measures. The program does not capture all direct and indirect costs borne by the program agency, including FTCA related expenses. The program knows the overhead costs associated with managing FTCA, but does not know the actual cost of FTCA coverage of health center providers in each fiscal year. The program is introducing procedures to improve cost forecasting for FTCA liabilities to the Federal government in the future. As noted in Section II, the program does use clear long-term growth goals to guide the use of funds. Applicable agency overhead, retirement, and other costs budgeted elsewhere. The program does not include informational displays in the budget that present the full cost of outputs.	The assessment is based on annual budget submissions to OMB and Congress. The program does not have an agency program budget estimate that identifies all spending categories in sufficient detail to demonstrate that all relevant costs had been included or a report that shows the allocation of overhead and other program costs to the program.	9%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Does the program use strong financial management practices?*	No	The program does not yet have a means to estimate future obligations for FTCA malpractice coverage, which can compromise financial planning for the program. Nor does it know yet the full cost of providing FTCA coverage for the last few years. FTCA provides unlimited coverage for medical malpractice claims. The health centers focus on providing care to low income patients means much of the care they provide is uncompensated, and are not expected to operate at a surplus. However, more than half of health centers report operating deficits from 1997 to 1999 and researchers have argued for an improvement in financial data over the UDS that would be more consistent and accurate. Other researchers have found deficits have declined in recent years. HRSA received its first clean audit in 1999 and 2000-2001 financial statements showed no material weaknesses. The OIG found in 2002 there was no evidence of substantive violations in HRSA's travel, appointments, and outside activities, but that there are technical lapses requiring improvement. The first construction loan guarantee went into default.	The assessment is based on agency financial statements, OIG audits, and documentation related to FTCA claims. The OIG reviewed audits of 33% of health center grantees in 1992 and found 46% had inadequate internal controls to prevent fraud, waste and abuse, 50% had inadequate accounting records and procedures, and 27% prepared inaccurate financial statements and reports. OIG found 1 in 6 health centers do not conduct outreach to enroll children in SCHIP and Medicaid expansions.	9%	0.0
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	The main deficiencies in this section include incentives and procedures to improve efficiency, the development of the full annual cost of operating the program, and financial management practices. The agency is taking meaningful steps to correct these deficiencies. The program anticipates having a system in place to project future FTCA claims by early 2003. The program has also undertaken initiatives to improve risk management for FTCA. The program also issued guidance this year to help centers facing serious financial problems develop a financial recovery plan. The program also issued guidance this year to consolidate grant award notices for health centers receiving funds from the various types of health center grants (e.g., community, migrant, homeless) into one notice. The program is also working on web-based applications, paperless grant submissions, and electronic grant review to improve efficiencies.	The program anticipates providing forecast information in early 2003 once a new claims database is in operation. The database is to be developed through a contract with the Princeton Company. The program will not rely on estimated obligations of each individual claim, but will develop actuarial estimates of future obligations aggregated by fiscal year. Guidance to grantees was provided in April of 2002 (PIN 18-02) to help health centers facing serious financial difficulties establish a financial recovery plan. Information technology consolidation efforts are designed to provide a single point of access for grantee submission and reporting and can improve program efficiency. Agency grant consolidation is expected to provide additional efficiency.	9%	0.1
8 (Co 1.)	*Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?*	Yes	Program applications for nationally announced competitive grant cycles are reviewed by objective review committees. The committees review the project plan and budget based on criteria announced publicly in the application guidance. Funding decisions are made based on committee assessments, relative need, announced funding preferences, program priorities, and periodic on-site reviews.	The procedures for grant applications are provided in Policy Information Notice 2001-18.	9%	0.1

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
9 (Co 2.) *Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	Yes	Many centers receive grants year after year. However, the program's policies and long-term goals encourage bringing in new grantees and the program can document these new entries in practice. The program announces new grants under a HRSA Preview announcement and indicates when new and first-time applicants are eligible. Pre-application workshops are also provided to help new grantees through the process. As part of the President's initiative to expand care provided by the Health Centers program, the agency has developed a web-based system to assist existing health center grantees apply to expand sites and to help prospective grantees apply for new funding.	In addition to guidance sent to existing grantees, the program posts information for new and existing grantees at a health center access points on line support page (http://bphc.hrsa.gov/dpspnewcenters/default.htm).	9%	0.1
10 (Co 3.) *Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	Program project officers in the field office conduct annual reviews of grantee continuation applications. The program obtains additional information through competitive applications for continuation funding at the end of the project period. Grantees are audited annually by independent accountants. Change of scope requests are reviewed by the program. The agency reports redirecting field office operations for enhanced oversight. One area of improvement can be related to medical malpractice, given the potential liabilities to the Federal government posed by FTCA coverage.	Data are gathered in annual UDS and other reports. A-133 audit findings are available to the program and public. Additional information is gathered from site visits and contact with project officers. FTCA deeming requires examination of new centers.	9%	0.1
11 (Co 4.) *Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	Health centers provide data annually to the agency. The program uses the Uniform Data Set to collect information for program performance measures and other indicators. Annual performance data are summarized in the performance report and made available on the agency web site. On a less systematic basis, performance data are also presented at conferences and other public presentations.	Assessment based on agency GPRA reports and web site (www.hrsa.gov).	9%	0.1
Total Section Score				**100%**	**82%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section IV: Program Results	**(Yes, Large Extent, Small Extent, No)**					
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Large Extent	The program has adopted new long-term goals for the growth initiative and to measure outcomes. The program's current performance suggests progress toward meeting its long-term goals. While partially an output measure, the first goal parallels the President's initiative. By definition, the growth initiative uses a baseline of 2001 and a target year of 2006. Past performance indicates the program has made progress overall in key areas.	The program's current performance suggests progress toward meeting its long-term goals. The baseline year for these goals is 2001 and in most cases 2002 data are not yet available. The target year for the long-term goals is 2006. The 2001 baseline figures indicate a positive level of initial performance that suggest the program is in a good position to make progress toward meeting its long-term goals. One data element that is available beyond the 2001 baseline is the number of new and expanded sites.	20%	0.1

Long-Term Goal I:	Broaden access to health care services for the underserved by increasing the number of new and expanded health center sites and additional people served.
Target:	(a) establish an additional 1,200 new and expanded sites and (b) serve 6.1 million more patients by 2006
Actual Progress achieved toward goal:	(a) 289 new or expanded sites in 2002, exceeded 2002 target by 11% (260); (b) 10.3 million in 2001 (an increase of 0.7 million above 2000, below target of 10.5 million)
Long-Term Goal II:	Assure access for nation's most vulnerable (measured by number and % of nation's population below 200% of poverty served by the program)
Target:	14.15 million served in 2006 -- and 16% of the nation's estimated population at or below 200% of poverty in 2006
Actual Progress achieved toward goal:	9.07 million persons in 2001 -- 11% of the nation's 80 million persons at or below 200% of poverty in 2000; 8.35 million in 2000 -- 10% of persons at or below 200% of poverty
Long-Term Goal III:	Reduce rate of low weight births among health center patients to nation's Healthy People 2010 goal of 6% of all births (new measure)
Target:	6.53% of all health center births in 2006
Actual Progress achieved toward goal:	7.13% in 2001; 7.14% in 2000; 7.37% in 1999

2	*Does the program (including program partners) achieve its annual performance goals?*	Yes	When compared against years prior to 2001, the program is achieving its annual performance goals. The annual goals mirror the long-term goals and are primarily outcome measures. Goals two and three are new measures.	Health center UDS data provide patient profiles to confirm that the most vulnerable continue to be served. Some data and outcomes are obtained by survey and special study on a periodic basis.	20%	0.2

Key Goal I:	Broaden access to health care services for the underserved by increasing the number of new and expanded health center sites and additional people served.
Performance Target:	(a) 260 new or expanded sites in 2002; (b) 10.5 million persons served in 2001
Actual Performance:	(a) 289 new or expanded sites in 2002 (exceeded target of 260 by 11%); (b) 10.3 million in 2001 (an increase of 0.7 million above 2000, below target of 10.5 million)
Key Goal II:	Assure access for nation's most vulnerable (measured by number and % of nation's population below 200% of poverty served by the program) (new annual measure)
Performance Target:	11.83 million by 2004; 14% of the nation's estimated persons at or below 200% of poverty in 2004
Actual Performance:	9.07 million in 2001; 11% of the nation's 80 million at or below 200% of poverty in 2000; 8.35 million in 2000; 10% of nation's population at or below 200% of poverty

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Key Goal III:		Reduce rate of low weight births among health center patients to nation's Healthy People 2010 goal of 6% of all births (new measure)			
	Performance Target:		6.77% by 2004			
	Actual Performance:		7.13% in 2001; 7.14% in 2000 and 7.37% in 1999			
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Large Extent	The program received a Yes in Question 4 of Section III. The program determined that the growth initiative will be most efficient by relying on a combination of new sites and expansions and has structured its growth to realize those efficiencies. Cost per encounter and medical team productivity have mirrored national averages. However, evaluations and other data collection do not indicate improvements in overall efficiency at the health center level. When comparing efficiency of health centers against national averages, significant changes in the composition of health center clients can be taken into account.	The program's grant as a share of total health center revenue has declined from more than 40% in the early 1990s to 25% in recent years, while the program has continued to serve more patients, suggesting improvements in leveraging funds beyond this program. Medical team productivity monitored at the Federal level has remained level at 4,200 encounters per year, which is comparable to industry standards. Costs per encounter have increased 5-7% per year since 1996, also comparable to national expenditures for outpatient medical care. With 50% of health centers reporting, the diabetes collaborative results suggest greater savings than care delivered elsewhere. The average number of sites each health center operates has increased.	20%	0.1
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Large Extent	The program is included in the health common measures along with the Defense, Veterans Administration, and Indian Health Service health care delivery activities. Based on data captured in the measures, the program compares favorably overall. The common measures track cost as measured by all Federal and non-federal revenue divided by the number of unique patient users; efficiency as measured by the annual number of outpatient appointments divided by provider full time equivalents; and quality as measured by the percentage of diabetics served by the program who received the HbA1c blood test in the past year. The program also compares favorably with other health delivery systems. (For more detailed information on the health common measures see www.whitehouse.gov/omb.)	Total revenue per unique patient users was $448 in 2001 and $467 in 2002. Other data from the common measures include roughly $3,200 for IHS, $4,900 for VA, and $3,600 for Defense. Annual outpatient appointments per FTE were 3,528 in 2001 and 3,475 in 2002. Other data include roughly 3,000 for IHS, 2,500 for VA and 3,900 for Defense. The percentage of diabetic patients who received an HbA1c blood test in the past year was 77% in 2001 and an estimated 75% in 2002. Other data include 95% for IHS, 93% for VA and 72% for Defense. Factors that complicate comparisons across participating agencies include the type of services provided, patient demographics and health status, methods of delivery, and program purpose. In addition, Medicaid beneficiaries served by health centers are less likely to be inappropriately hospitalized and receive care at less cost than those cared for elsewhere. Primary care quality is higher than most HMO plans.	20%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Yes	As noted in Section II, independent evaluations have been conducted that provide an overall view of program performance and help fill gaps in performance information. Recent evaluations indicate the program is effective and achieving results. The HHS-supported 1% evaluation studies highlight program results in specific areas. GAO reports indicate the program has areas of needed improvement, but is effective in providing care for underserved populations. UDS data show the program reaches uninsured and low-income user targets. User survey data compared to the National Health Information Survey show women cared for in health centers receive age appropriate screening at a rate above the national average and minority patients report blood pressure is under control above comparison groups.	In addition to agency supported surveys and UDS data, independent evaluations indicate the program is effective overall. A 1998 evaluation by MDS Associates found Medicaid health center users experience 22% lower hospitalization rates than Medicaid users receiving care from other sources. A 1998 evalulation by the Lewin Group found average managed care health center network costs were lower than the average network costs. Health centers report higher maternity admissions, but lower or comparable hospital admissions. A Kaiser commissioned report on 1998 HEDIS data found health center owned health plans performing better than other Medicaid-dominated plans, including immunization rates, well care visits, cervical cancer screening, and children's access to care. GAO reported in 2000 that an increasing proportion of health center patients are uninsured and that the program is helping centers plan strategically and participate in managed care. The report also confirmed lower hospitalization rates and other health center results.	20%	0.2
Total Section Score					**100%**	**80%**

OMB Program Assessment Rating Tool (PART)

Competitive Grant Programs

Name of Program: Health Professions

Section I: Program Purpose & Design (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	No	The agency articulates the program purpose as addressing the failure of the market to assure an adequate distribution of health care providers to all areas of the country and all population groups. While in itself clear, this core purpose described by program managers is not cited or emphasized in the authorizing legislation, views of interested parties, or agency documents. The legislative structure and number of problems the program could conceivably address have resulted in a wide variety of purposes held by interested parties. The program primarily provides grants to academic institutions to subsidize the cost of health professions education and training. The grants include primary care, dentistry, nursing, geriatrics, pediatric dentistry, rural health, allied health, preventive medicine, public health, and health administration. The three most commonly cited purposes are to improve the supply, minority representation, and distribution of health care providers. Various efforts tie to market failure, but the variety of stated purposes presents significant challenges, including to show an impact in each area.	The legislative history of the Health Professions program consists primarily of a layering on of authorizations, followed by limited consolidations. In 1956, the first major authorization in the Public Health Service Act for the general training of health practitioners focused on increasing the supply of nurses and mental health professionals. Today, the Health Professions constitute over 40 separate activities. Some of the Health Professions activities correspond directly with one of the frequently cited purposes, such as training for diversity. In general, the authorizing legislation itself does not specifically emphasize the most frequently cited purposes of the Health Professions program, but instead establishes a list of programs each with its own purposes and funding. The Administration has tended to focus on diversity and distribution. Congressional committees often focus on the program as a means of helping rural areas. Advocates also emphasize the financial vulnerability of funded institutions and the amount of program funding that is provided by State or discipline.	20%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program address a specific interest, problem or need?*	Yes	Diversity and distribution of health professionals are specific and current problems that the program is designed to address. Health Professions training grants were created nearly 40 years ago in response to an anticipated national shortage of physicians. Since that time, the program has developed to address a number of different issues. Some Health Professions grants are specifically designed to provide assistance to minority and disadvantaged individuals. In addition to the distribution and diversity of health professionals, a key specific problem that is still relevant to current conditions includes the supply of nursing professionals. Many other program purposes do not respond to currently relevant problems.	Data are available on the problems of poor distribution and diversity of health professionals, and the supply of nursing professionals. For example, the agency projects a 13% shortage of registered nurses in 2010; under-represented minorities account for 26% of the population, but African Americans and Hispanics compose only 12% of the health professional workforce; roughly 20% of Americans live in rural areas, but only 9% of physicians practice there.	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	No	The Health Professions program is divided among various authorities with a multitude of goals and purposes and is not designed to have a significant impact on any one factor such as diversity, distribution, supply, or quality. Further, the national impact of the program in these areas is generally not known. Training of the Nation's health professionals is a large and complex problem. The program has a very broad reach. For most awards supported by the program, there are no matching requirements, but some grant activities have the effect of leveraging other funds and the program is credited with helping launch new training programs in institutions by providing seed money. In addition, disadvantaged students benefiting from scholarships and loan subsidies report the support makes a significant impact in their ability to continue their education. Also, the growth of managed care can reduce the amount of discretionary revenue available to teaching hospitals.	The program funds 1,700 institutions nationwide, constituting a significant reach, and institutions receiving Title VII and VIII support succeed in also receiving state funds. However, each issue the program is designed to address today presents a significant challenge on its own upon which the impact of the program is not known. Health care is a labor intensive industry and requires a high level of investment in education and training. An estimated 39 million people lack health insurance. According to agency estimates, there are over 3,000 primary medical health professional shortage areas that would need over 14,000 primary care physicians to meet national standards. The US has the highest health spending as a percentage of GDP in the world. According to a UCSF report, less than 15% of medical graduates choose residencies for primary care.	20%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	Health professions institutions receive Federal support from numerous sources. The Health Professions program is different in structure and goals from Federal graduate medical education (GME) subsidy payments for Medicare and Medicaid. Federal Medicare GME statutes and Medicaid policies do not specify specific policies and purposes to drive desired outcomes. Medical schools also receive significant resources from the National Institutes of Health, but to support research and research professionals. While the Bureau of Labor Statistics tracks health careers, the program is also the only Federal entity dedicated to studying healthcare workforce supply and demand. A key focus of the program is the distribution of primary care and other health professionals. The National Health Service Corps shares that general purpose, but has an entirely different design. NHSC is focused on improving care in targeted communities and supports professionals through a different mechanism and stage in the career.	Payment for residency training in medicine dates back to the original Medicare and Medicaid legislation of 1965. At $378 million in FY 2002, the Health Professions program is a fraction the size of Medicare and Medicaid GME payments. The FY 2002 Budget for the National Institutes of Health was $23.6 billion. The National Health Service Corps aims to improve the distribution of physicians by providing loan repayment awards and scholarships to healthcare providers in exchange for serving in an underserved community.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The program is administered through competitive grants and cooperative agreements to academic and medical institutions and contracts and awards to individual students and faculty, providing direct contact to influence changes at the institutional and student or faculty member level. Having a clearly stated purpose will aid in planning and budgeting and will also help clarify program purpose among interested parties over time.	There is no evidence that providing support through a block grant or other mechanism would be more effective or efficient than competitive awards direct to institutions.	20%	0.2
Total Section Score					**100%**	**60%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning		**(Yes, No, N/A)**				
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	The program adopted new long-term goals during the assessment process. The long-term measures focus on the program's national impact with respect to regular access to a health care provider, the portion of program beneficiaries who go on to serve in target areas, and the portion of program beneficiaries who are underrepresented minorities and/or from disadvantaged backgrounds.	The program has three long-term measures with targets: 1) Increase the proportion of persons who have a specific source of ongoing care to 96% by 2010; 2) Increase the proportion of health professionals trained in Titles VII and VIII Health Professions supported programs serving in medically underserved communities to 40% by 2010; 3) Increase the proportion of graduates and program completers of Title VII and VIII Health Professions supported programs who are underrepresented minorities and/or from disadvantaged backgrounds to 50% by 2010. Reliable baseline data are not yet available.	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	The program has adopted a limited number of annual performance goals that demonstrate progress toward desired long-term outcomes. These goals are clustered in two areas: eliminate barriers to care and eliminate health disparities.	Health Professions annual goals include: 1. Increase the number of graduates and/or program completers who enter practice in underserved areas, 2. Increase the number of graduates and/or program completers of health professions primary care tracks and programs that support primary care, 3. Increase the number of minority/ disadvantaged graduates and program completers.	14%	0.1
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	Individual service grantees provide performance data through a common reporting system to measure annual goals. Further steps to use data to reward performance could encourage additional buy-in to program goals.	Grantees report on performance data for the annual goals through the agency's Comprehensive Performance Management System (CPMS) and Uniform Progress Report (UPR). The agency has been working to improve the timeliness and response rates for those data. Project officers review data against application targets.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	The program has been looked to as a partner within the Federal government because it provides grants to such a large number of health professions institutions. The program includes a group of interdisciplinary program grants specifically designed to improve collaboration between academic institutions and states and communities, and has promoted practitioner level collaboration through its innovation awards. The program has worked with other bureaus within the Department in geriatrics, substance abuse faculty development and chiropractic demonstrations. Medicare, through its reimbursement for teaching costs related to the provision of services to Medicare beneficiaries, is the largest explicit Federal source of graduation medical education funding. However, Medicare's statutory purpose is not designed to meet physician workforce policy goals and the program is limited in its ability to collaborate with Medicare on workforce policy issues.	The program collaborates with numerous national organizations such as the Federation of Associations of the Schools of the Health Professions, Council on Medical Education, the American Medical Student Association, and multiple professional associates. According to the National Conference of State Legislatures, the program also works with states, which are often focused on addressing health professions distribution issues. Additional collaboration with other Federal activities that share similar goals such as the National Health Service Corps in the form of meaningful actions in management and resource allocation may be beneficial.	14%	0.1
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	No	Regularly scheduled objective, independent evaluations of the program are not supported. While the program has some outcome data in its GPRA performance report, there are insufficient data on the effectiveness of the program overall at meeting key objectives to require evaluations that merely fill gaps in performance information.	Reports from the General Accounting Office in 1994 and 1997 pointed to a lack of comprehensive evaluations of the Health Professions program. Some targeted evaluations have been conducted. An evaluation of the Health Careers Opportunity Program was conducted in 1994 by Houston Associates, Inc. The program plans a contract with the Institute for College Research Development and Support to examine the number of HCOP program participants that enter and graduate from health professionals school. HRSA supported an evaluation of the Centers of Excellence in 2001. Some surveys have been used such as with Title VIII and Faculty Loan Repayment. Evaluations of the Area Health Education Centers and Workforce Information and Analysis are planned. Evaluations of other programs have been published in journals, such as for the Interdisciplinary Generalist Curriculum and Faculty Development Fellowships.	14%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	The program does not base a determination of the level of financial resources on what is needed to obtain annual and long-term goals. Nor does the program tie specific funding levels to each discrete output goal. The task of alignment for this program is made more difficult by the number of discrete grant activities. The program is able to estimate outputs based on past experience, but cannot estimate unit costs and cannot allocate resources by output goal. The program has struggled in advancing its strategic planning and setting budgets according to what is needed to obtain goals in part because of stark differences between annual budget request and final appropriations. Certain sub-activities such as scholarships may be more able to align budget and legislative changes with performance.	This assessment is based on the annual budget submission to OMB and the Congress, and other information provided by the agency.	14%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	The main deficiencies highlighted in this section are in conducting comprehensive and independent evaluations, and integrating budget and performance. The agency overall is making organizational changes which will further integrate budget and performance planning. Additional work is needed to schedule comprehensive evaluations of ongoing programs.	The assessment is based on discussions with the agency. Title VIII programs are working with George Mason University to improve their understanding of the impact of funding, policy and legislative changes on performance. Evaluations of the Area Health Education Centers and Workforce Information and Analysis are planned. The agency's electronic data system can also improve the use of performance information in budgeting and planning.	14%	0.1
Total Section Score					**100%**	**71%**
Section III: Program Management (Yes, No, N/A)						
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	No	There is little evidence to date of the program overall using performance data to adjust program priorities, make resource reallocations, or take other management actions. Performance information is collected annually from award recipients. The agency collects data through the CPMS/UPR data management system. Other need-based programs rely on financial status reports of award recipients. These data are primarily used to monitor grantee compliance with project goals and objectives and to design technical assistance for poor performers. There are exceptions where more recently, data are being used by managers in budget and management decisions.	Some evidence of exceptions is available, including the Health Careers Opportunity Program use of performance information to adjust future program efforts. Program managers added a funding priority for enhancing enrollment in generic baccalaureate nursing education.	9%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Are Federal managers and program partners (grantees, sub grantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The agency's senior managers are held accountable for operations of their programs, including performance results, through their annual performance contracts. HRSA reports all of its SES personnel have performance contracts with goals, standards and outcomes that are results oriented. For many Health Professions grants, continued funding requires meeting grant objectives. Accountability of award recipients could be improved and performance information could be extended to program staff performance evaluations or contracts.	The Centers of Excellence program reports funding only those continuations that meet program goals. Scholarships for Disadvantaged Students recently increased performance levels as a condition of receiving additional funds. The Health Careers Opportunity Program rates renewal grant applications based on past performance. In the last grant cycle, of the 34 renewal applications submitted, 13 were approved. Nursing Workforce continuations are also based on past progress. The FY 2003 Primary Care Medicine and Dentistry application includes quality of objectives and outcome measures in the review criteria. The ability of the program to hold some grantees accountable through reductions in future awards could be limited by the pool of potential applicants because there are a limited number of accredited programs eligible for funding.	9%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	The program obligates funds in a timely manner. Scholarships are made in time to reallocate declined awards. Award recipients report on planned and actual expenditures. There have been very few known cases of funds being expended outside of their intended purpose. Project officers perform site reviews when possible.	Assessment based on apportionment requests; annual budget submissions and financial reports, queries in Single Audit Database and agency grants management procedures. Many awards are made to conform to the academic calendar.	9%	0.1
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	In general, the program does not have incentives and procedures in place to improve efficiency and cost effectiveness in program execution. The agency did begin collecting data from grantees electronically for the first time in FY 2002 and plans an expansion of electronic transactions.	There is little evidence that the program has incentives and procedures in place to improve efficiency and cost effectiveness in program execution.	9%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program does not have a procedure for splitting overhead and other costs between outputs. The program does not have a financial management system that fully allocates program costs and associates those costs with specific performance measures, or even a consistent way to develop full cost of achieving performance goals. The program does not capture all direct and indirect costs borne by the program agency, including applicable agency overhead, retirement, and other costs budgeted elsewhere, or include informational displays in the budget that present the full cost of outputs. Given a budget total, the program can estimate indirect costs and administrative costs of awards based on ceilings established in legislation and grants policy, administrative costs and overhead, and predict the number of students trained and other outputs.	The assessment is based on annual budget submissions to OMB and Congress. The program does not have an agency program budget estimate that identifies all spending categories in sufficient detail to demonstrate that all relevant costs had been included or a report that shows the allocation of overhead and other program costs to the program. Program managers budget for grants, grant review, travel and technical assistance. Staffing, space, and overhead are budgeted for within the agency program management budget line.	9%	0.0
6	*Does the program use strong financial management practices?*	Yes	HRSA received its first clean audit in 1999. The 2000-2001 agency financial statements showed no material weaknesses. HRSA financial statements are conducted by the Program Support Center. The OIG found in a 2002 audit of HRSA's travel, appointments, and outside activities that there was no evidence of substantive violations, but that there are technical lapses requiring improvement. The agency disagrees with the breadth of the problem and has re-issued guidance to improve oversight. The OIG FY 2001 report notes cites weaknesses in HRSA's grant accounting systems found by an independent auditor and cites for example that Health Professions expenses increased 150% despite total appropriations increasing 75%.	In a serious of audits of universities participating in the health professions student loans program, the OIG found universities were generally in compliance, but inappropriately carrying uncollectible loans in their accounting records. The OIG has recommended that the agency better emphasize regulations on uncollectible loans in the program.	9%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	The agency is taking steps that could improve its efficiency, including plans to extend electronic transactions. The program is taking steps to further integrate performance in review criteria for some grants. Additional steps are needed to improve the use of performance information to make budget and management decisions.	The agency is moving toward an electronic application process, which may improve efficiency in program execution. Federal staff office consolidations and reorganizations the agency is undergoing may improve the efficiency of Federal staff allocations.	9%	0.1
8 (Co 1.)	*Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review*	Yes	Most grants and cooperative agreements are awarded using a peer-review process with clear criteria. Annual appropriations bills do not earmark funds for grant recipients in the program. Overall, the agency's process is open and based on objective criteria.	Assessment based on grant review procedures and Federal Register Notices.	9%	0.1

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
9 (Co 2.) *Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	Yes	The program operates a fair and open competition within the guidelines of its authorizing legislation and provides a reasonable amount of outreach. The application process used by the program encourages the participation of new/first time grantees through preferences and priorities. Grant announcements and materials are available on the agency's web site and the agency hosts regional meetings, conference calls and one-on-one contacts to provide technical assistance to new grantees. Many Title VII program award recipients have received funds for over 30 years. The number of eligible applicants for some grants is limited to accredited programs, which increases the likelihood that the same institutions will receive grants time and again. However, increased reliance on performance data from those institutions is merited to discontinue funding to schools that do not meet standards required for the program to succeed in meeting its new performance measures.	Assessment based on agency announcements and historical data on grant awards. The program notes that 50% of competitive applicants awarded primary care and medicine grants in FY02 had not received funding the previous year. The August 9 2002 Federal Register notice specifies a funding preference for new programs. Title VII primary care grants have provided support to 100% of the Nation's family medicine departments in medical schools. The agency cites a funding priority for Title VIII nurse managed centers that have not received funding previously.	9%	0.1
10 (Co 3.) *Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	Award recipients provide data annually to the agency on performance and expenditures. Project officers also work directly with grantees. Site visits are made for special cases to monitor progress. Scholarship programs collect data through applications and annual financial status reports.	Data are gathered in annual reports. Additional information is gathered from site visits and contact with project officers. The Health Careers Opportunity Program and Centers of Excellence project officers complete quarterly and annual reports on assigned grantees.	9%	0.1
11 (Co 4.) *Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	Award recipients provide data annually to the agency. Annual data are summarized in the performance report and made available on the agency web site. On a less systematic basis, performance data are also presented at conferences and other public presentations.	Assessment based on agency GPRA reports and web site (www.hrsa.gov).	9%	0.1
Total Section Score				**100%**	**73%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section IV: Program Results (Yes, Large Extent, Small Extent, No)						
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	No	The program has adopted new long-term goals for the program to measure outcomes, but needs more than one year of data to show progress for the first goal. A small or large extent would require data for the second and third measures and more definite progress on the first measure. The first measure, the proportion of persons who have a specific source of ongoing care, is a proxy measure correlated with improving access to care. Data indicate uneven progress, but some improvement. The following two measures focus on outcome of training with respect to the proportion of program beneficiaries who are serving in medically underserved communities and who are from underrepresented minorities and/or disadvantaged backgrounds. The measure on minority and disadvantaged backgrounds excludes grantees in a few states prohibited by law from collecting the data.	The baseline year for these goals is 2001 and in most cases 2002 data are not yet available. The target year for the long-term goals is 2010. The first measure is not subject to changes in definition and area fragmentation that limit the utility of tracking impact through shortage area designations. While the measure does not capture all of the specific activities of the program, it is the most focused on final outcomes from the perspective of the problem and relates directly to the bulk of program efforts.	20%	0.0

Long-Term Goal I:	Increase the proportion of persons who have a specific source of ongoing care. (new measure)
Target:	96% by 2010
Actual Progress achieved toward goal:	86% in 2001, 85% in 2000, 84% in 1999, 85% in 1998
Long-Term Goal II:	Increase the proportion of all health professionals completing Title VII and Title VIII funded Health Professions programs serving in medically underserved communities. (new measure)
Target:	40% by 2010
Actual Progress achieved toward goal:	Baseline under development.
Long-Term Goal III:	Increase the proportion of all health professionals completing Title VII and Title VIII funded Health Professions programs who are underrepresented minorities and/or from disadvantaged backgrounds. (new measure)
Target:	50% by 2010
Actual Progress achieved toward goal:	Baseline under development.

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program (including program partners) achieve its annual performance goals?*	Small Extent	The agency has the most direct influence over the percentage of health professionals who benefit from the program that train in these areas. Because of this influence and the correlation between training in underserved areas and eventually practicing in underserved areas, the program believes the first annual measure will provide data most useful to ongoing management with respect to improving the distribution of health professionals. The first measure is also significant for interdisciplinary grants funded by the program. Annual output data are available in the agency's annual performance plans. Performance on previously held related measures has exceeded goals in some areas including the number of students in training with organizations serving underserved areas and the number of minority/disadvantaged graduates and program completers. Actual performance has declined in some key goals, including number of graduates entering underserved areas and number going into primary care and the number of disadvantaged enrollees.	Related to the first measure, in FY 1999, 32,629 residents/graduates, students/trainees and faculty supported by the program were training in underserved areas, up from roughly 26,300 in 1998. Related to the new second annual measure, in FY 1999 4,336 health professionals entered service in underserved areas out of roughly 89,295 total program completers (4.9%). Related to the third measure, 10,158 health professions residents/graduates and faculty are from underrepresented minority/disadvantaged backgrounds. Comparable data from FY 1998 or FY 2000 are not available.	20%	0.1

Key Goal I:	Increase the percentage of health professionals supported by the program training in underserved areas. (new measure)
Performance Target:	30% by 2004
Actual Performance:	Baseline under development.
Key Goal II:	Increase the percentage of health professionals supported by the program who enter practice in underserved areas. (new measure)
Performance Target:	30% by 2004
Actual Performance:	Baseline under development.
Key Goal III:	Increase the proportion of all health professionals completing Title VII and Title VIII funded Health Professions programs who are underrepresented minorities and/or from disadvantaged backgrounds. (new measure)
Performance Target:	40% by 2004
Actual Performance:	Baseline under development.

3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	No	The bulk of evidence shows with respect to the performance of program grantees, the program has not demonstrated improved efficiencies and cost effectiveness in achieving the program's annual goals. In addition, the OIG found in 2002 that institutions participating in the faculty loan repayment program frequently waive matching requirements, reducing the impact per Federal investment.	The total Federal investment per placement in an underserved area has increased over the last three years. The total Federal investment per clinician trained and per minority graduate has decreased. The total Federal investment per primary care graduate, per minority enrollee, and per minority faculty has also increased. An exception involves Title VIII programs' use of conference call peer review rather than on-site review for small grants limited to $25,000.	20%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Small Extent	The program is not part of the common measures exercise. However, there are some programs that support similar efforts. Federal Graduate Medical Education payments support training in the health professions. With respect to programs that share the same goals, the National Health Service Corps shares the goal of placing providers in underserved areas. Neither GME nor NHSC provides a direct comparison, but the NHSC is most closely aligned with respect to program goals. The program's performance comparison between the two programs is mixed.	By statute, the program provides more direction than GME and its grant recipients and program completers are more likely than the national average to provide care in underserved areas and represent a minority background. GME payments are not directed to proactively encourage improvement in the diversity and distribution of the nation's healthcare workforce. With respect to Health Professions' sister entity, the NHSC, the program is less efficient in placing medical professionals in shortage areas than the NHSC. According to the most recent data available, in 2000 the average cost per placement was $77,400 for the Health Professions and $47,900 for the NHSC.	20%	0.1
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	No	The agency has not had a comprehensive evaluation on the program as a whole, or on the main components including training grants and loans and scholarships. Prior to the latest reauthorization of the Health Professions programs, GAO noted in 1997 that effectiveness has not been shown and the impact of the components will be difficult to measure without common goals, outcome measures, and reporting requirements. Academic studies of the issue indicate the underlying premise of the program, to reduce shortage areas by training professionals who may be more likely to serve there, could work. For example, researchers have found publicly owned medical schools in rural states have higher proportions of graduates entering practice in rural areas than private medical schools that are not focused on family medicine and are located in urban areas.	No comprehensive evaluations are available, but there are some performance evaluations available with varied findings worth noting. GAO reported minority representation has improved more quickly in the health professions funded by the program than for professions requiring only a high school degree and not funded by the program. A 2001 Mathematica report found schools receiving additional Professional Nurse Traineeship funds from the program actually have fewer graduates employed in schools with medically underserved communities than schools without. The report found requiring students to sign a commitment to work in an underserved community resulted in a higher number entering service there, an important finding for program planning efforts. The OIG found in 2002 that institutions participating in the faculty loan repayment program frequently waive matching requirements, reducing the impact per Federal investment. In relative terms, a more comprehensive 2002 study of Title VII by departments of family medicine and pediatrics was published in Family Medicine.	20%	0.0

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
			The authors of the Family Medicine article matched grant funding from 1978 to 1993 with the specialty and practice locations of graduates of departments of family medicine. The review found 1.5% of physicians trained by institutions receiving a Title VII grant between 1978 and 1993 serve in shortage areas, compared to 1.1% of those trained by institutions not funded by the program. Institutions receiving the most grants from the program had a rate of 1.3%. The only funded institutions with a rate below non-funded institutions were those receiving only faculty training grants (0.8%). Based on these data, if funded institutions placed graduates at a rate equal to non-funded institutions, 479 fewer physicians would serve in shortage areas. The authors calculate $290 million in grants to departments of family medicine over this period. Total Federal spending for the Health Professions program from 1978 to 1993 was $5.7 billion.		
Total Section Score				**100%**	**13%**

Program Assessment Rating Tool (PART)

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: Authorizing statute established the NIH Office of AIDS Research (OAR) and explicitly designates OAR as the primary Federal entity with responsibility to oversee (including plan, coordinate, and evaluate) all AIDS research conducted or supported by the NIH Institutes. Subsequent appropriations bills and report language further clarifies/strengthens OAR's responsibility to determine jointly with the NIH Director on the annual allocation of AIDS funding among NIH Institutes.

Evidence: Section 2351 of the National Institutes of Health Revitalization Act of 1993, P.L. 103-43; OAR mission statement; OAR provisions in L/HHS/Ed appropriations bills and report language from fiscal years 1998-2003.

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The NIH AIDS research program was established in direct response to an emerging public health threat. Nearly 60 million people worldwide cumulatively have been infected with HIV; AIDS has killed more than 22 million people. OAR's role is to identify scientific areas within the HIV/AIDS portfolio that require focused research and facilitate multi-Institute research efforts to address them. While the disease continues to expand and evolve in the U.S. and world-wide overtime, the overarching priorities that continue to frame the NIH AIDS research agenda are: 1) prevention research to reduce HIV transmission, including the development of vaccines, microbicides, and behavioral interventions; 2) therapeutics research to develop simpler, less toxic, and cheaper drugs adn drug regimens to treat HIV infection and its associated illnesses, malignancies, and other complications; 3) international research in developing counties; and 4) research targeting the disproportionate impact of AIDS on minority populations in the United States.

Evidence: CDC Surveillance Reports (http://www.cdc.gov/hiv/stats/hasr1302.htm); USAID "Report on the Global HIV/AIDS Espidemic"; CIA National Intelligence Estimate "The Global Infectious Disease Threat and Its Implications for the United States"; CIA Report "The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China."; annual NIH Plan for HIV-Related Research.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: The NIH AIDS research program is the largest public investment in AIDS research in the world. The 1996 Levine Report concluded that "Without a strong stimulous from NIH that includes much needed basic information, the waning private sector interest in an HIV vaccine may vanish altogether." NIH's therapeutic research and prevention strategies are the foundation for HRSA. CDC, SAMHSA, CMS, USAID and others to implement their own agency goals. A few foundations, such as Gates, the American Foundation for AIRS Research, Elizabeth Glaser Pediatric AIDS Foundation and IAVI have small targeted research programs that do not compete with NIH, but rather often supplements or complements NIH research. None of these efforts compare to the size, volume, comprehensiveness, or collective achievement of the NIH AIDS research program.

Evidence: Document: NIH Sponsored Studies Effecting Progression to AIDS; Kalichman et al. Prevention of sexually transmitted HIV infection: a meta-analytic review of the behavioral outcome literature. Annals of Behavioral Medicine 1996; 18:6-15.; Pendergast et al. Meta-analysis of HIV risk-reduction interventions within drug abuse treatment programs. Journal of Consulting and Clinical Psychology. 2001; 69:389-405.; CDC Research Synthesis Project. JAIDS. 2002, 30:S94-S105.; Card et al. The HIV/AIDS Prevention Program Archive: A collection of promising prevention programs in a box. AIDS Education and Prevention. 2001;13:1-28.; "Discovery Lays Groundwork for Potential New Class of Anti-HIV Drugs (NIAID News 3/31/03).; Citations Data reflecting the prolific citations of NIH investigated AIDS research published by ScienceWatch.

Program ID: 10001050

Program Assessment Rating Tool (PART)

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: NIH AIDS research is supported by nearly every NIH Institute and Center, according to its mission and expertise both extramurally and intramurally through a wide variety of research grant mechanisms. This flexible and crosscutting design allows scientists to research AIDS from multiple perspectives and are consistent with recommendations from independent evaluations. Based on a comprehensive strategic plan that clearly establishes the areas of scientific endeavor and the research priorities, the program design of peer-reviewed, competitive grants allow NIH to respond in a balanced way to close knowledge gaps by issuing directed research program announcements, support emerging scientific opportunities, and address foreseen changes in the disease and unforseen public health contingencies. Peer-reviewed, investigator-initiated research is the accepted gold standard for funding the most meritorious, diverse, and productive science. OAR's three percent transfer authority gives OAR the ability to fully coordinate the diverse AIDS-related research carried out by all NIH Institutes.

Evidence: 1991 Institute of Medicine Study on The AIDS Research Program of the National Institutes of Health; 1996 Report of the NIH Research Program Evaluation Task Force; 1997 NIH Plan to Implement Recommendations of the NIH AIDS Research Program Evaluation Task Force; Section 208 of the L/HHS General Provisions -- OAR 3 percent transfer authority.

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: The AIDS-related research portfolio is based on the annual comprehensive NIH Plan for HIV-Related Research, which targets: 1) emphasis areas such as Natural History and Epidemiology, Etiology and Pathogenesis, Therapeutis, Vaccines, and Behavioral and Social Science; 2) cross-cutting science areas such as Racial and Ethnic Minorities, Microbicides, Prevention Science, Women and Girls, International Research, Training, Infrastructure/Capacity Building, and Information Dissemination; 3) scientific priorities and opportunities; and 4) populations at risk. This Plan drives the budget development process. Institutes develop individual strategic plans to implement initiatives, based on the overarching OAR HIV-Related Plan, specific to their missions. A standing general provision permits the OAR Director, jointly with the NIH Director, to transfer between NIH Institutes up to three percent of the funding determined by NIH to be related to AIDS research. The AIDS Research Information System enables the OAR to track and monitor all AIDS research expenditures according to the objectives of the Plan.

Evidence: 1992 Institute of Medicine Study on The AIDS Research Program of the National Institutes of Health; 1996 Report of the NIH Research Program Evaluation Task Force; 1997 NIH Plan to Implement Recommendations of the NIH AIDS Research Program Evaluation Task Force; research that shows balanced priorities between treatment for those already infected and prevention strategies for those at risk; peer review to ensure meritorious science is supported; outside expert advice to help establish ongoing five scientific priorities; increased emphasis on vaccine research based on the state of the science; and increased emphasis on women, minorities, and international, based on disease burden.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 11%

Explanation: The two long-term performance goals signaled out for GPRA purposes are: 1) Develop an HIV/AIDS vaccine by 2007, and 2) By 2007, evaluate the efficacy of three new treatment strategies for HIV infection in phase II/III clinical trials in an effort to identify drugs that are more effective, less toxic and/or simpler to use that the current recommended HIV treatmetn regimen.

Evidence: NIH OAR GPRA plan (http://www.nih.gov/od/oar/public/pubs/fy2004/fy2004CJ.pdf); OAR Strategic Plan (http://www.nih.gov/od/oar/public/pubs/fy2004/i_overview.pdf)

Program ID: 10001050

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 11%

Explanation: VACCINE: At present there is no HIV/AIDS vaccine. An effective vaccine is critical to worldwide efforts to control HIV/AIDS and offers the best hope of halting the HIV/AIDS pandemic. THERAPUETICS: Complications are emerging from the current HAART therapy regimen so there is an urgent need for the discovery and development of new drugs that are less toxic, simpler to use, and affordable. Both the vaccine and therapeutics goals have established time frames.

Evidence: NIH OAR GPRA plan (http://www.nih.gov/od/oar/public/pubs/fy2004/fy2004CJ.pdf); OAR Strategic Plan (http://www.nih.gov/od/oar/public/pubs/fy2004/i_overview.pdf)

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: YES Question Weight: 11%

Explanation: NIH has identified several annual targets that tie back to the OAR strategic plan for both vaccines and therapeutics. For vaccines, the OAR strategic plan includes basic research, vaccine development, study populations and infrastructure development, and clinical trials. For Therapeutics, the OAR strategic plan includes basic research, clinical trials, drug complications, coinfections and manifestations, and mother-to-child transmission.

Evidence: OAR Strategic Plan This can be found on the internet at: http://www.nih.gov/od/oar/public/pubs/fy2004/i_overview.pdf Therapeutics are covered in Chapter IV and Vaccines in Chapter V.

2.4 Does the program have baselines and ambitious targets for its annual measures? Answer: YES Question Weight: 11%

Explanation: The baseline is the state of the science for the year proceeding the annual targets. The program has quanitifiable targets for the year that are necessary for achieving the long-term performance goals.

Evidence: OAR Strategic Plan This can be found on the internet at: http://www.nih.gov/od/oar/public/pubs/fy2004/i_overview.pdf Therapeutics are covered in Chapter IV and Vaccines in Chapter V.

2.5 Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program? Answer: YES Question Weight: 11%

Explanation: NIH's government partners (CDC, DOD, VA) serve on the OAR Advisory Council. Government partners also frequently serve on Planning Groups for the annual NIH Plan for HIV-Related Research. NIH Institutes and Centers commit to OAR goals by issuing RFAs, PAs, and RFPs that have been reviewed by OAR so that they are consistent with the NIH Plan for HIV Related Research. AIDS Research Information System (ARIS) is a early notification system that codes the grant to an objective in the plan. All intramural and extramural grant awardees are required to submit annual reports outlining their scientific progress toward the achievement of the grant or project's objectives.

Evidence: ARIS (including an IC funding sheet for coding); Institute and Center Strategic Plans that tie to the OAR Strategic Plan; Example of an RFP from NHLBI

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: YES Question Weight: 11%

Explanation: Evaluations of the AIDS program are conducted by outside experts on an ongoing basis on multiple levels: 1) The broad AIDS program objectives are evaluated by congressionally-mandated Advisory Councils that are appointed by the Secretary; 2) Program areas with multi-institute support are subjected to OAR sponsored reviews of program areas; 3) Specific extramural targeted programs are reviewed by Institute convened groups that evaluate projects, including site visits by program staff and outside reviewers; 4) The Levine Report recommended the formation of working groups to critically examine extramural AIDS research. These groups are not FACAs, but rather are independent investigators that examine the state of the NIH portfolio and provide recommendations; 5) Intramural AIDS research projects are reviewed by Boards of Scientific Counselors, comprised of scientific experts from academia and industry.

Evidence: The evidence corresponds to the numbers in the Explanation box: 1) The Levine Report is the most recent example of a comprehensive review (1996), The Prevention Science Working Group and the Therapeutics Research Working Groups rosters, missions, and reports; 2) OAR reviews and reports; 3) IC-specific program reviews; 4) An example of a working group, including links to the meeting minutes: http://www.niaid.nih.gov/daids/vaccine/avrc.htm; 5) Examples of intramural projects reviewed by Boards of Scientific Counselors every four years

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 11%

Explanation: The NIH has been budgeting by its strategic plan. This presentation does not explicitly tie budget resource levels to annual and long-term performance targets. The budget requests do not show how much it would cost to achieve the performance results.

Evidence:

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: NO Question Weight: 11%

Explanation: Currently, NIH does not have a plan to address how the agency would revamp its budget requests to explicitly tie the accomplishment of goals to resource levels.

Evidence:

2.RD1 **If applicable, does the program assess and compare the potential benefits of efforts within the program to other efforts that have similar goals?** Answer: NA Question Weight: 0%

Explanation: As discussed in detail in question 1.3, the NIH AIDS Research program is the largest public investment in AIDS research, and therefore, is not comparable to other programs.

Evidence:

Program Assessment Rating Tool (PART)

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

2.RD2 **Does the program use a prioritization process to guide budget requests and funding decisions?** Answer: YES Question Weight: 11%

Explanation: OAR workshops utilize input from non-NIH experts from academia, foundations, industry, and the community. Annually, Planning Groups assess the state of the science in view of the previous year's plan and then strategies/objectives are reviewed and updated, eliminating, adding and reprioritizing objectives. Scientific priorities narrowly define key areas deemed worthy of new/expanded funding based on current knowledge, opportunities, or gaps. The Budget explicitly ties to these priorities. ICs submit AIDS-related research budget requests to OAR focusing on new/expanded program initiatives for each scientific area. Proposals are reviewed in relation to the Plan and to other IC missions to eliminate redundancy and assure cross-institute collaboration. Awards are made based on the scientific priority of the proposed initiatives at each step of the budget process up to the final congressional appropriation. There is no funding formula for when funding levels change. Rather, dollars are allocated and balanced based on scientific opportunity and IC capacity to absorb and expend resources to the most meritorious science.

Evidence: NIH OAR GPRA plan (http://www.nih.gov/od/oar/public/pubs/fy2004/fy2004CJ.pdf) OAR Spending by the NIH Plan for HIV-Related Research table; OAR AIDS funding by Institute and Center table; OAR AIDS Research Priorities as the Respond to the AIDS epidemic graph; IC funding codes table

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 12%

Explanation: Performance data are collected when grants/contracts are submitted (peer-reviewed baseline data) and during the award, both extramurally and intramurally. Monitoring includes: progress reports, correspondence, audit reports, site visits, annual invention utilization reports, lobbying disclosures, specialized programmatic reports, and publications of objectives, methodology, and findings. A reduction in budget, withholding support, or termination may and has resulted from substandard data, insufficient patient accrual/retention into clinical studies, inadequate progress in fulfilling the research agenda, noncompliance with Federal regulations, or the Term of Award. Contract project officers monitor the performance/quality of deliverables to ensure the statement of work is fullfilled within the designated time and those that dont are terminated. Since 1956, NIH Intramural research is periodically reviewed by a Board of Scientific Counselors that assess research activities, progress, and the future direction of labs. Recommendations affect future resources such that some intramural labs are expanded, contracted, or even closed.

Evidence: Example of redacted portion of a recommendation memo from an NIH Board of Scientific Counselors; Example of a Request for Application (RFA) for an adult therapeutic AIDS clinical trials program that shows specific eligibility/review criteria for the network (of grantees) to establish procedures for assessing performance of individual sites and the entire network (e.g., procedures on adding/eliminating sites or laboratories based on performance, redistributing resources, establishing site-specific and overall group plans to ensure enrollment of demographically diverse populations, especially women and minorities, and establishing community advisorty boards); Letters from Congress regarding failure of sites to successfully recompete in Pediatric AIDS Clinical Trials Network; Dec. 22, 1999 NIAID newsletter on five existing sites being "phased-out" as a result of recompetition.

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?**

Answer: YES Question Weight: 12%

Explanation: All NIH employees have performance plans or contracts, assessed twice yearly by supervisors, to evaluate job performance. Sustained unsatisfactory performance, violation of Federal laws/regulations, or gross negligence leads to suspension and/or dismissal from Federal employment. Grant administration is the joint responsibility of the NIH Institute Program Director and the Grants Management Specialist. Program Directors are responsible for the grant's scientific, technical, and programmatic issues and receive annual reports documenting progress, proprietary information relative to patent applications, and scientific articles submitted/published in peer reviewed journals. The Grants Management Specialist is responsible for the grant's business aspect and is authorized to obligate NIH at the expenditure of funds and permit changes to approved projects. The contract's administration is the joint responsibility of the NIH Institute Project Officer and Contract Officer. The Project Officer monitors the technical aspects of the project and the Contract Officer is empowered to execute or modify a contract.

Evidence: DHHS Grants Admnistration Manual (http://www.hhs.gov/grantsnet); NIH Grants Policy Statement (http://grants1.nih.gov/grants/policy/policy.htm); Compendium of Findings from proactive compliance site visits (http://grants1.nih.gov/grantscompliance/compendium 2002.htm); Grant application (PHS 398); and Financial Status report Standard Forms 269 & 269A.

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?**

Answer: YES Question Weight: 12%

Explanation: Authorizing legislation P.L. 103-43 requires OAR to allocate appropriated funds to the Institute "...to the extent practicible, be made no later than 15 days after the date on which the Director receives amounts..." Historically, OAR has allocated th eappropriated funds within one week of appropriation. An allocation letter from OAR is transmitted to the Institutes and Centers to inform their overall funding allocation along with a list of programmatic priorities approved for funding. AIDS grants are also subject to "expedited review" required by law to be processed and reviewed within 6 months from receipt deadline to funding decisions as opposed to the standard 9 months for non-AIDS grants. OAR tracks and monitors the actual expenditure of funds by area of emphasis/object codes. Careful program management planning and employment of strict financial management procedures ensure the limited amounts of unobligated funds remain at the end of each fiscal year. OAR records show that historically, less than $10,000 has remained unobligated by the end of each fiscal year.

Evidence: FY 2003 allocation letter fro the OAR Director to an NIH Institute Director; schedule of AIDS application receipt dates.

Program:	HIV/AIDS Research
Agency:	Department of Health and Human Services
Bureau:	National Institutes of Health
Type(s):	Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

3.4 **Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: YES Question Weight: 12%

Explanation: Intramural labs use competitive bidding to purchase equipment, supplies, and reagents so that AIDS funding achieves the maximum cost-efficiency in advancing scientific progress. Basic lab supplies and chemical reagents are stocked in central stores on the NIH campus permiting competitive pricing for large quantities of common items. NIH uses a contracting mechanism to acquire supplies, services, equipment, construction, and IT. Services include the conduct of clinical trials, breeding, maintenance/provision of non-human primates, production/testing of specific reagents, and manufacture of doses of vaccine candidates. RFPs or Invitation for Bids (IFBs) are issued for specific goods and services and are announced through the Federal Business Opoportunities website, the single government point-of-entry for Federal Government procurement opporunities over $25,000. OAR also has an IT system (ARIS) that prevents redundant funding of grants.

Evidence: www.FedBizOpps.gov; http://www.arnet.gov/far; "The Guide to the NIH Acquisition Process," http://www.hhs.gov/ogam/oam/procurement/hhsar.html; OAR proposal for a new ARIS database system.

3.5 **Does the program collaborate and coordinate effectively with related programs?** Answer: YES Question Weight: 12%

Explanation: The Global AIDS Research Strategy Group established by the OAR provides a forum for information exchange and discussion of current and planned international HIV research efforts. Participants include CDC, FDA, PHAP, DHHS, DOD, DoS-USAID, ONAP, the World Bank, and USAID. NIH collaborates with DoD, CDC, AHRQ, FDA, HRSA, and the Pan American Health Organization (PAHO) on natural history and epidemiology studies. NIH works closely with FDA to monitor drug development and expedite approval of new drugs. The NIH-sponsored HIV Vaccine Trials Network (HVTN) is a coordinated global network for conducting phase I, II, and II clinical trials of HIV vaccine candidates in 17 domestic and 10 international sites. Sub-studies designed by NIH and CDC are performed within HVTN clinical protocols. The NIH-sponsored HVTN is a comprehensive multi-center network of 9 U.S. and 16 international sites dedicated to research on non-vaccine methods to prevent HIV transmission. In collaboration with CDC, NIH supports the AIDS International Training and Research Progeram to address research training for scientists and health care workers from 55 resource-poor countries.

Evidence: Since the beginning of the epidemic, the NIH AIDS research program has collaborated with otehr government agencices, industry, community organizations, international organizations, foundations, and scientific societies in the U.S. and overseas to plan, coordinate, carry out resaerch, train sicentists, and disseminate research information. Provided as evidence are ongoing and previous NIH trans-government collaborations in HIV-related research.

3.6 **Does the program use strong financial management practices?** Answer: NO Question Weight: 12%

Explanation: The most recent audit cited NIH's financial reporting and processes as a material weakness. NIH's Central Accounting System (CAS) lacks intergration with its subsidiary systems. The report stated that the financial reporting systems and processes used by NIH were not capable of producing reliable financial statements in a timely manner. Reconciliation of certain accounts were not done in a timely manner, which required extensive research and analysis of various account balances before NIH's fiscal 2002 financial statements were considered completed.

Evidence: NIH Independent Auditor's Report and Financial Satements, September 30, 2002 and 2001; NIH FY 2003 Third Quarter Financial Management Progress Report.

Program Assessment Rating Tool (PART)

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

3.7 **Has the program taken meaningful steps to address its management deficiencies?** Answer: YES Question Weight: 12%

Explanation: NIH has implemented a detailed financial management corrective action plan with milestones, appointed responsible offices and points of contact, target dates, and completion dates. The plan is on track to fully implement NIH's new NBRSS financial management system (a part of the larger HHS-wide Unified Financial Management System effort) by FY 2005.

Evidence: FY 2002 NIH Corrective Action Plan

3.RD1 **For R&D programs other than competitive grants programs, does the program allocate funds and use management processes that maintain program quality?** Answer: YES Question Weight: 12%

Explanation: Research grants are awarded competitively for a finite amount of time, at the end of which they must recompete through peer review. Key criteria considered by the peer-review group in making recommendations for continuation include past performance and scientific progress in reaching the goals established in the individual project application. Grant applications may be unsolicited (investigator-initiated) or in response to targeted initiatives (Program Announcements, Request for Applications, and Request for proposals), all of which are peer-reviewed for quality. Grant applications/contract proposals submitted in response to a specific task or service are subjected to dual level peer review. Criteria may include the need to demonstrate that an applicant has previous clinical trial experience, a definitive plan for the recruitment/enrollment of diverse populations, or plans to establish and maintain a community advisory board to ensure community involvement in the planning, design, and conduct of clinical studies.

Evidence: DHHS Grants Admnistration Manual (http://www.hhs.gov/grantsnet); NIH Grants Policy Statement (http://grants1.nih.gov/grants/policy/policy.htm).

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: VACCINES: By NIH's own admission, the vaccine goal will not be achieved by 2007. However, significnat progress has been made. In humans, NIH has conducted more than 50 Phase I and Phase II clinical trials of more than 30 vaccine products. At least 10 new candidates will enter Phase I trials in the next two years. The VRC recently launched the first Phase I clinical trial of a multi-clade, multi-gene vaccine candidate. Since January 2003, 3 vaccine candidates have entered trials in the US or international sites. THERAPEUTICS: Since 1996, several new classes of antiretroviral drugs, including fusion inhibitors (FI), protease inhibitors (PI), and nucleotide analogues (NA) have been developed and proved to be safe:1 FI, 6 PIs, 1 NA, 2 nucleoside reverse transcriptase inhibitors, and 3 non-nucleoside reverse transcriptase inhibitors have been licensed. Several combination drug therapies have recently been approved. In the past 6 years, the FDA has approved more than 10 new treatments targeting HIV-related OIs and cancers.

Evidence: Vaccine pipeline charts indicate progress toward achieving a safe and efficacious vaccine; PHaRMA therapeutics document; JAMA, July 25, 2001; NIH Stories of Discovery

Program Assessment Rating Tool (PART)

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: LARGE EXTENT Question Weight: 25%

Explanation: New annual targets were identified through the PART that are quantifiable and more ambitious. NIH has a systematic process to collect information about scientific advances and achievements as they relate to these targets. Prior to their development, NIH reported annual progress in the NIH GPRA plan. While these old targets were too vague, they do relate to the revised annual targets and the progress is applicable. VACCINES: Design and development advances of vaccine strategies to fuel the pipeline of promising vaccine candidates include: emergence of new vaccine concepts; advancement into preclinical testing; successful use of animal models; the initiation of new clinical trials; and collaborations with scientists in developing countries. THERAPEUTICS: While no specific GPRA targets existed, the OAR Strategic Plan does chronicle annual progress to improved treatment strategies, including reduction of patient viral loads, increased CD4 cells counts, decreased opportunistic infections, and improved immune functions in patients who are able to adhere to treatment regimens and tolerate toxicities.

Evidence: Highlights of NIH Scientific Accomplishments and Advances in AIDS Research During the Era of the Five-Year Doubling; NIH GPRA Plans 1999 to 2004; Science Advances/Stories of Discovery.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: YES Question Weight: 25%

Explanation: Examples of NIH's improved efficiencies: Expedited Follow-up: VAXGEN's overall efficacy failed, but it did possibly provide immune protection in minority populations. NIH's large repository of samples from vaccinated volunteers allowed it to take stored frozen samples and rapidly confirm immunogenicity in minorities/women in previous trials, resulting in time and cost savings from eliminating an additional Phase II trial before staging a larger Phase III trial. ARIS: the system is being improved/upgraded to accomodate all budget functions and to improve the tracking and monitoring of the AIDS portfolio. New Procedures: 1) Expedited Review ensures all AIDS grants are processed/reviewed in 6 months as opposed to the standard 9 months for non-AIDS grants. 2) Streamlining allows grant reviewers to unanimously agree on applications in the lower half that will not be discussed or scored at the meeting. Prospective grantees do receive the reviewer's comments. 3) NIH-managed AIDSinfo is a collaborative effort with CDC, CMS, and HRSA to provide a single, searchable resource for HIV/AIDS treatment and prevention guidelines.

Evidence: Expedited Follow-up can be found at Section 2302 of the Public Health Service Act; Streamlining is described in two CSR documents, "Review Procedures for Scientific Review Group Meetings" and "Streamlined Review Procedures Used in CSR"; NIH FY 2004 Plan for HIV-Related Research; ARIS redesign plan; AIDSinfo: http://aidsinfo.nih.gov

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: NA Question Weight: 0%

Explanation: Per discussion in questions 1.3 and 2RD1, the NIH AIDS research program is the largest public investment in AIDS research, and therefore, is not comparable to other programs.

Evidence:

Program Assessment Rating Tool (PART)

Program: HIV/AIDS Research
Agency: Department of Health and Human Services
Bureau: National Institutes of Health
Type(s): Research and Development

Section Scores				Overall Rating
1	2	3	4	
100%	78%	88%	75%	Moderately Effective

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?**

Answer: YES

Question Weight: 25%

Explanation: NIH regularly ulitizes independent evaluations to assess both program structure and performance on multiple levels. The last comprehensive study, the Levine Report (1996) concluded that NIH investment in AIDS research is of the highest quality and relevance. The NIH AIDS investment has yielded the natural history of the disease, prevention strategies, and clinical and basic research advancements. A 1991 IOM report "The AIDS Research Program of the NIH" states: The committee has carefully examined NIH's organizational and procedural arrangements for reviewing and awarding AIDS-related research grants and concludes that currently they are adequate." A 1999 CFAR focus group reported that the program "has been successful in a number of areas, particularly with regard to fostering collaboration between existing research programs related to HIV and AIDS."

Evidence: Report of the NIH AIDS Research Program Evaluation Working Group of the OAR Advisory Council, 1996. Report of the Working Group to Review the NIH Perinatal, Pediatric, and Adolescent HIV Research Priorities, 1999.; Report of the Focus Group to Review the Centers for AIDS Research Program, 1999.; Selected Outside Reviews of NIH AIDS Research Programs from 1993 to date.

PART Performance Measurements

Program: HIV/AIDS Research

Agency: Department of Health and Human Services

Bureau: National Institutes of Health

Measure: By 2010, develop an HIV/AIDS vaccine.2005 Targets: 1) Expand breeding of non-human primates: 3 centers; 2) Test 1 new virus stock; 3) Test 2 vaccine candidates in animals; 4) Phase I human trials: 1 vaccine candidate; 5) Seroincidence data: 3 sites; 6) Evaluate vaccine safety: 2 labs; 7) Initiate 4 phases I and II vaccine trials; 8) Produce candidate vaccine for phase III trials.

Additional Information: The development of a safe and effective vaccine against HIV is critical to worldwide efforts to control AIDS and is the best hold for halting the pandemic.

Year	Target	Actual	**Measure Term:** Long-term
2005	See targets		
2007	original date		
2010	revised date		

Measure: By 2007, evaluate the efficacy of 3 new treatment strategies for HIV infection in phase II/III clinical trials.2005 Targets: 1) Develop 3 anti-HIV compounds; 2) Initiate 4 drug clinical trials; and 3) Develop/test 2 agent to prevent/treat drug complications; and 4) Develop/test 1 new approach to inhibit mother-to-child transmission.

Additional Information: Complications are emerging from the current HAART therapy regimen so there is an urgent need for the discovery and development of new drugs that are less toxic, simpler to use, and affordable.

Year	Target	Actual	**Measure Term:** Long-term
2005	See targets		
2007	3 new treatments		

Program Assessment Rating Tool (PART)

Program: Hospital Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	63%	56%	22%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The purpose of this program is to prepare hospitals and supporting healthcare systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies.

Evidence: (1) Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107-188) authorizes Sec. 319C of the Public Health Service Act. (2) Funding provided in 2003 Consolidated Appropriations Act (Public Law 108-7)

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The need to improve hospital and healthcare system preparedness in the case of an attack or other public health emergency remains. The risk of attack was made clear by the events of September 11, 2001 and the antrax attacks of the fall of 2001. GAO reports have documented wide-spread deficiencies in the capacity, communication, coordination and training elements required for preparedness and response. In May, 2001, an Americal Journal of Public Health Survey was published results indicating a lack of preparedness, including: less than half (45%) of hospitals had an indoor or outdoor decontamination unit with isolated ventilation, shower, and water containment systems, but only 12% had 1 or more self-contained breathing apparatuses or supplied air-line respirators. Only 6% had the minimum recommended physical resources for a hypothetical sarin incident.

Evidence: (1) GAO Report 03-373, "Bioterrorism: Preparedness Varied across State and Local Jurisdictions" (2) GAO Report 02-149T, "Bioterrorism: Review of Public Health Preparedness Programs" (3) GAO Report 02-141T, "Public Health and Medical Preparedness" (4) American Journal of Public Health Preparedness, May, 2001 - http://www.ajph.org/cgi/content/abstract/91/5/710

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: This is the only program whose mission is focused on preparing hospitals and other health care providers to respond to a terrorist attack or mass casualty emergency. CDC's grant program focuses on public health infrastructure, and DHS first responder grants focus on emegency (non-medical) response.

Evidence: (1) Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107-188) authorizes this activity as part of an overall, coordinated approach to public health preparedness, including CDC public health grants.

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: There is no evidence that a different design would be more effective. HRSA approves each state's planned use of these funds, ensuring that they are used for their intended purpose. In addition, the cooperative agreement guidance prohibits supplantation, and HRSA project officers are required to address this point with awardees.

Evidence: National BHPP Cooperative Agreement Guidance for FY 2003

Program Assessment Rating Tool (PART)

Program: Hospital Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	63%	56%	22%	Results Not Demonstrated

1.5 **Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly?** Answer: NO Question Weight: 20%

Explanation: Funds are distributed through a Congressionally established formula that provides every state with a base amount, and the remainder through a population factor. This design ensures that every state can make some capacity improvements, while larger states receive greater assistance. However, this design is not optimal past the short term. Currently, most states have great need and can put the base amount to good use. However, this will not always be the case. In addition, population is not an exact proxy for need of assistance. To avoid distributing scarce resources to states with lesser need, assessments should be done to determine each state's capacity compared to its need. Funding should be distributed to states according to their need for assistance, and demonstrated ability to use funds to make the required improvements. Otherwise, the program can not be accurately described as effectively targeted. HRSA has taken the appropriate approach of making funds available for capacity enhancements on a regional basis, rather than providing equal capacity to every hospital. This increases cost effectiveness, and diminishes the extent to which funding is provided to entities that do not need it.

Evidence: National BHPP Cooperative Agreement Guidance for FY 2003

2.1 **Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program?** Answer: YES Question Weight: 12%

Explanation:

Evidence: see Measures tab

2.2 **Does the program have ambitious targets and timeframes for its long-term measures?** Answer: YES Question Weight: 12%

Explanation:

Evidence: see Measures tab

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 12%

Explanation:

Evidence: see Measures tab

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation:

Evidence: see Measures tab

Program Assessment Rating Tool (PART)

Program: Hospital Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	63%	56%	22%	

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: Awardees are committed to the annual and long-term goals of the program, as established in the cooperative agreement guidance.

Evidence: National BHPP Cooperative Agreement Guidance for FY 2003

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: NO Question Weight: 12%

Explanation: No independent evaluations have been conducted.

Evidence:

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: Budget submissions are not tied to the achievement of specific performance targets. States must report what they do with grant funds, and HRSA can ensure that funds are used consistent with broad program goals and focus areas, but funding requests are not tied to achievement of specifc goals within specific timeframes. Budget requests are not detailed enough, and funding levels are tied more to total authorization level than to specific objectives.

Evidence:

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: NO Question Weight: 12%

Explanation: HRSA has not made arrangements to establish an independent evaluation, and there is no evidence that budget requests will be handled differently.

Evidence:

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 11%

Explanation: Performance data is reported semi-annually by each State. HRSA then tabulates this data into a comparative data report, which is used during weekly awardees calls to make awardees aware of trends and other useful information.

Evidence: Cooperative Agreement allows HRSA to tailor information requirements.

Program: Hospital Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	63%	56%	22%	Results Not Demonstrated

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: NO Question Weight: 11%

Explanation: Federal and state managers are not yet held accountable for program performance in a systematic way.

Evidence: Federal managers track state performance, including the establishment of certain key positions, (see BHPP Database Report) but do not use program performance to hold managers accountable.

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: YES Question Weight: 11%

Explanation: Federal funds from this program have been obligated in an extremely timely manner. Information on state obligations not made available. HRSA ensures that funds are used for their intended purposes.

Evidence: The Secretary made it a priority for both CDC and HRSA to release these funds as soon as possible. Federal funds were appropriated on January 10, 2002 and 20% were released by CDC to state by February, with the remainder released in June, 2002. All funding requests are reviewed for consistency with program purpose.

3.4 **Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: NO Question Weight: 11%

Explanation: While HRSA does take some steps to promote efficiencies, without efficiency goals included in their strategic planning and performance plans, other steps are insufficient.

Evidence: Performance measures do not include any efficiency goals. While HRSA does take steps to cost-effectiveness, including adopting a model of regional preparedness rather than equal improvements to every hosptial or health care center -- such steps are insufficient without a focus on cost-effectiveness and efficiency in strategic and performance planning.

3.5 **Does the program collaborate and coordinate effectively with related programs?** Answer: YES Question Weight: 11%

Explanation: This program, along with the CDC Public Health Preparedness Grants program has been an example of coordination within HHS. HRSA has also required coordination with entities outside of HHS in the cooperative agreement guidance, and to report on such coordinated activities in the semi-annual reports.

Evidence: HHS has taken steps to ensure coordination within the Department, with the Assistant Secretary for Public Health and Emergency Preparedness taking a strong role in coordinating HRSA and CDC efforts in this area. This includes joint grant announcements, and simultaneous release of funding, and cross-references in HRSA and CDC cooperative agreements. In addition, HHS has entered into a Memorandum of Agreement with DHS on related/shared responsibilities. See also BHPP Cooperative Agreement Guidance for FY 2003.

Program: Hospital Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	63%	56%	22%	

3.6 Does the program use strong financial management practices? Answer: NO Question Weight: 11%

Explanation: The September 30, 2002 and 2001 independent auditor's report identifies five reportable conditions. 1) Preparation and analysis of financial statements - HRSA's process for preparing financial statements is manually intensive and consumes resources that could be spent on analysis and research of unusual accounting. 2) HEAL program allowance for uncollectible accounts HRSA's financial statements indicate limited success in collecting delinquent HEAL loans. 3) Federal Tort Claims Liability HRSA is unable to estimate its malpractice liability under the Health Centers program. 4) Accounting for interagency grant funding agreements HRSA's interagency grant funding agreement transactions are recorded manually and are inconsistent with other agencies procedures. 5) Electronic data processing controls HRSA has not developed a disaster recovery and security plan for its data centers. Although HRSA's hospital preparedness program has not been cited specifically by auditors for material weaknesses, the above reportable conditions constitute weaknesses within HRSA and its Office of Financial Integrity. The Office reports directly to the Administrator and is intended to ensure procedures are in place to provide oversight of all of HRSA's financial resources.

Evidence: 1) CORE Accounting Form 2) HRSA Office of Financial Integrity description 3) HRSA FY 2002 Annual Report

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 11%

Explanation: HRSA has used information gathered so far to to adjust the guidance, and include an improved electronic budget table developed based on state feedback that now assists States in managing their resource allocations. In addition, HRSA will be implementing a number of IT improvements to increase efficiency and improve program management. Finally, HRSA developed a corrective action plan to address the reportable conditions identified in the September 30, 2002 and 2001 independent auditor's report. For each aspect of the five reportable conditions, HRSA assigned an office responsibility. The plan also outlines milestones and target completion dates.

Evidence: Evidence includes: 1) National BHPP Cooperative Agreement Guidance for FY 2003; 2) HRSA Corrective Action Plan for FY2002 Financial Statement Audits as of 4/30/2003.

3.BF1 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: YES Question Weight: 11%

Explanation: Cooperative agreement guidance requires semi-annual reporting on awardee activities. HRSA project officers also conduct site-visits and regular conference calls with awardees.

Evidence: National BHPP Cooperative Agreement Guidance for FY 2003

3.BF2 Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner? Answer: NO Question Weight: 11%

Explanation: The program collects information from awardees semi-annually, and summarizes it in a database. However, information is not made available publicly, in part due to security concerns.

Evidence:

Program Assessment Rating Tool (PART)

Program: Hospital Preparedness Grants
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	63%	56%	22%	Results Not Demonstrated

4.1 Has the program demonstrated adequate progress in achieving its long-term performance goals? Answer: NO Question Weight: 33%

Explanation: The program has really only had one year of funding, in FY 2002 - and at a much lower level than was provided for FY 2003 and requested for FY 2005. Therefore, there is not yet strong information to demonstrate progress toward long-term goals.

Evidence:

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: SMALL EXTENT Question Weight: 33%

Explanation: Reports from the first year of funding show a degree of initial progress, particularly in the area of planning.

Evidence: Information reported from May, 2002 application and November 2002 semi-annual report.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: NA Question Weight: 0%

Explanation: Program only begun in FY 2002 - with only one year of funding, there is no way to demonstrate improved efficiency.

Evidence:

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: SMALL EXTENT Question Weight: 33%

Explanation: This program has existed for a shorter period of time, and therefore cannot demonstrate similar progress to other efforts designed to increase preparedness against a terrorist attack or public health emergency. However, initial progress made with funding in its first year indicates, to some extent, a favorable comparison.

Evidence:

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results? Answer: NA Question Weight: 0%

Explanation: No independent evaluations have been conducted as this program was first funded in FY 2002.

Evidence: No independent evaluations have been conducted.

Program ID: 10001053

PART Performance Measurements

Program: Hospital Preparedness Grants

Agency: Department of Health and Human Services

Bureau: Health Resources and Services Administration

Measure: Percentage of hospital regions that have achieved a surge capacity of 500 persons per million in all hospital regions, for response to terrorism and other public health emergencies.

Additional Information: The purpose of this measure is to better protect Americans by achieving a surge capacity of 500 persons per million in all hospital regions, for response to terrorism and other public health emergencies.

Year	Target	Actual	**Measure Term:** Long-term
2005	75%		
2006	85%		
2007	95%		
2008	100%		

Measure: Percentage of awardees that have implemented regional plans and meet all major milestones established for all of the HRSA priority areas to meet the goal of a surge capacity of 500 persons per million population.

Additional Information: HRSA priority areas include: governance and administration; regional surge capacity; emergency medical services; linkages to public health departments; and terrorism preparedness exercises.

Year	Target	Actual	**Measure Term:** Annual
2005	75%		
2006	85%		
2007	95%		
2008	100%		

Measure: Percentage of awardees that will demonstrate their ability to secure and distribute pharmaceutical resources required in emergency events, including coordinated caches of pharmaceuticals from metropolitan medical response systems, sufficient to treat 500 persons per million population, as certified to by HRSA.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2005	75%		

PART Performance Measurements

Program: Hospital Preparedness Grants

Agency: Department of Health and Human Services

Bureau: Health Resources and Services Administration

Measure: Percentage of awardees that will demonstrate their ability to secure and distribute pharmaceutical resources required in emergency events, including coordinated caches of pharmaceuticals from metropolitan medical response systems, sufficient to treat 500 persons per million population, as certified to by HRSA.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2006	85%		
2007	95%		
2008	100%		

Measure: Percentage of awardees that have (1) assessed the existing chemical and radiological response equipment they currently possess, (2) acquired the needed additional equipment as identified in that assessment, and (3) have trained hospital and emergency medical service personnel likely to respond/treat 500 persons per million population, chemically or radiological contaminated.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2005	75%		
2006	85%		
2007	95%		
2008	100%		

Measure: Percentage of awardees that have successfully demonstrated their ability to evaluate, diagnose, and treat 500 adult and pediatric patients per million population resulting from emergency events, meeting HRSA criteria, as evidenced in reviews of annual drill reports.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2005	75%		
2006	85%		

PART Performance Measurements

Program: Hospital Preparedness Grants

Agency: Department of Health and Human Services

Bureau: Health Resources and Services Administration

Measure: Percentage of awardees that have successfully demonstrated their ability to evaluate, diagnose, and treat 500 adult and pediatric patients per million population resulting from emergency events, meeting HRSA criteria, as evidenced in reviews of annual drill reports.

Additional Information:

Year	Target	Actual
2007	95%	
2008	100%	

Measure Term: Annual

OMB Program Assessment Rating Tool (PART)

Direct Federal Programs

Name of Program: IHS Federally-Administered Activities

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	Provide comprehensive health care services to the American Indian/Alaska Native (AI/AN) population.	Treaties between the Federal government and Tribes are the foundation. Statutes, beginning with the Snyder Act, authorize this activity.	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	In FY 2001, IHS served 985,400 AI/AN in rural, isolated communities. There is a 31% poverty rate on reservations. Consequently, there are severe health disparities between the AI/AN population and other U.S. populations (see next column).	In 1997, the death rates in the AI/AN population were greater for alcoholism (638%), TB (400%), diabetes (291%), unintentional injuries (163%), suicide (91%), and pneumonia and flu (67%).	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	Serves as a safety net by providing rural healthcare to AI/AN population in isolated communities. There is evidence of health status improvements over time. IHS collaborates with other federal agencies, private, non-profit and academic sectors to accomplish the program purpose.	Between 1972-74 and 1994-96, IHS reduced: maternal mortality by 78%; TB mortality by 82%; infant mortality by 66%; and gastrointestinal disease mortality by 76%.	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	IHS facilities are the primary source of health care for the AI/AN population and this effort is not duplicated by any other federal or state program. It is not likely that comprehensive health care services would be otherwise provided to this population by private or non-profit entities especially in rural, isolated communities where few or no health care access points currently exist.	An analysis of facilities approved for the priority list for replacement shows that the average distance to another health facility is 68 miles.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	It is not likely that grants/contracts would be sufficient to entice private or non-profit entities to operate facilities and recruit staff and providers to deliver health care in a rural, isolated setting. Further, the Indian Self-Determination Act (ISDA) authorizes tribes to assume these operations and responsibilities at their request.	The primary alternative to the direct federal program is tribal contracting. Tribal contracting is more expensive due to contract support costs (Tribes serve 27% of AI/ANs, but receive 50% of the IHS budget excluding facilities).	20%	0.2

Total Section Score	100%	100%

Section II: Strategic Planning (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	IHS has adopted specific long-term performance goals with specific outcome targets for 2010. These goals and targets have been integrated into the IHS Strategic Plan. In addition, IHS has created and charged the ITU (Indian/Tribal/Urban) Obesity Coordinating Committee "to catalyze a coordinated and comprehensive public health effort to treat and prevent obesity in the AI/AN population." A performance goal to decrease obesity rates in the AI/AN population will result from this effort as will the process measures, etc. necessary to develop the goal. The Committee will hold its first meeting in January 2003.	(1) Decrease the Years of Productive Life Lost (YPLL) by 20% by 2010 (baseline and target to be developed by October 2003); (2) Increase "ideal" (based on American Diabetics Association guidelines) blood sugar control in AI/AN diabetics to 40% by 2010; and (3) Decrease obesity rates in AI/AN children (2-5 years) by 20% by 2010 (baseline and target to be developed by October 2003).	16%	0.2
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	IHS has a number of annual performance goals in its Performance Plan that support the long-term performance goals recently integrated into the IHS Strategic Plan.	Examples: (1) Reduce the number of deaths due to unintentional injuries to AI/AN ; (2) Increase the percentage of diabetics with "ideal" blood sugar control; and (3) Decrease obesity rates in AI/AN children (2-5 years) (annual target to be established in FY 2006) .	16%	0.2
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	Tribal and non-Tribal contractors receiving Contract Health Services funds support the IHS mission, annual and long-term performance goals, treatment priorities and data submission requirements.	Tribal contractors, in fact, commit to the performance goals through the tribal consultation process with IHS. Non-Tribal contractors must adhere to the data submission requirements in the contract to receive Contract Health Services funds.	16%	0.2

4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	IHS collaborates and coordinates effectively with other Department of Health and Human Services (DHHS) agencies, agencies of other Departments and non-governmental agencies that share similar goals and objectives.	For example, IHS and CDC annually develop an umbrella work plan that includes specific agreements with CDC entities. IHS also participates in the VA Pharmaceutical Prime Vendor Program to purchase drugs at substantially discounted prices.	15%	0.2
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	IHS hospitals and ambulatory facilities are subjected to accreditation surveys by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Association for Ambulatory Health Care (AAAHC) on a regular basis. 78 IHS facilities were surveyed in 2000; JCAHO surveyed 81% of these.	In 2000, the average score for a IHS hospital surveyed by JCAHO was 91 (on a scale of 100). 60 % of all organizations surveyed by JCAHO in 2000 received a score of 91 or higher. All IHS-operated facilities were accredited (one Tribal-operated facility was recommended for non-accreditation pending appeal). The average score for a IHS ambulatory facility by JCAHO was 93 (on a scale of 100). 56% of all organizations surveyed by JCAHO in 2000 received a score of 94 or higher. All IHS (and Tribal)-operated ambulatory facilities were accredited.	15%	0.2
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	IHS cannot provide a valid cost accounting link to health outcomes by specific activity and respective funding sources. IHS aggregates its budget categories into four areas (Treatment, Prevention, Capital Programming/Infrastructure and Partnerships, Consultation, Core Functions, and Advocacy) for GPRA.	IHS FY 2003 Performance Plan, pp. 42-45.	15%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	No	IHS has adopted the aggregation approach as a "reasonable" approach for a comprehensive public health program. IHS is working to disaggregate the inputs for dental services, mental health, and public health nursing, but states it cannot do so for the other activities because of multidisciplinary interventions.		7%	0.0
Total Section Score					**100%**	**78%**

Section III: Program Management (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	IHS collects timely and credible performance information, and the information is used at the local, Area and Headquarters (HQ) levels to manage the program. Though some IHS funds are allocated by a historical base funding basis, the majority of funds are allocated to the Areas based on need. In addition, Area Directors are given some discretionary funds to allocate.	In IHS' FY2003 Performance Plan, 26 of 27 performance indicators were reported for FY 1999; 33 of 34 for FY 2000; and 26 of 38 for FY 2001. At the local level, GPRA+ software and PCC+ allows managers to generate reports on clinical GPRA indicators and billing and provider documentation, respectively. The software is also used to measure the impact of business and/or clinical process changes implemented to improve performance on specific indicators. The clinical performance information is used by local and Area management to support onsite training in response to identified deficiencies and inefficiencies. At the Area level, reports on GPRA and other clinical indicators are reviewed mid-year and annually. At the HQ level, an Immunization Initiative was implemented in FY 2002 to address the failure to meet immunizations performance target and a decision was made to not fund Diabetes programs that do not submit required data.	15%	0.2
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The IHS Director has a performance contract with the Secretary to achieve performance goals. The Area Directors have elements in their performance plan to achieve performance measures.	In addition to performance goals, the Area Directors also have a financial element in their performance plan to assess their management of agency resources.	15%	0.2
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	Funds for IHS' four largest funded activities (Hospitals and Clinics, Dental Health, Direct Operations, and Mental Health which account for 58 % of the Services budget) are obligated fairly consistently over the year.	IHS headquarters staff track obligations and conduct monthly conference calls with Area Directors to discuss any irregularities.	15%	0.2

4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	IHS has established a performance based contracting goal with frequently used providers for Contract Health Services funds. This performance measure improves the cost effectiveness of procurement of inpatient and outpatient hospital services.	Savings are computed annually by the IHS Fiscal Intermediary. The latest available data are 95% complete and show that IHS achieved $182.5 million in savings in FY 2001 through contractual rate agreements with frequently used providers.	15%	0.2
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	A budget aggregation approach is utilized for program performance so program performance changes are not identified with changes in program fundling levels. The authority granted to Tribes by the Indian Self-Determination Act (ISDA) to assume control of their health care delivery system through contracting requires that IHS be able to transfer the full program costs, including administrative costs and allocated overhead. Consequently, IHS tracks the program costs for contracted and retained funds in the headquarters and area offices.		15%	0.0
6	*Does the program use strong financial management practices?*	No	The audited financial statements contain material weaknesses with respect to the timeliness of preparation and analysis and reconciliation of financial statements. OMB reviewed the last five statements and each of them contained these findings of material weaknesses. IHS has a manual, intensive process for tracking and reconciling its finances which is inefficient. In its Areas, IHS is implementing a business plan for internal management and operation at its facilities. IHS is also producing more cost reports for its hospitals and clinics.	DHHS Office of Inspector General's Report on the Financial Statement Audit of the Indian Health Service for Fiscal Years 1995, 1997, 1998, 1999 and 2000. A review of the Draft Independent Auditor's Reports and Financial Statements September 30, 2001 and 2000 is consistent with these findings.	15%	0.0
7	*Has the program taken meaningful steps to address its management deficiencies?*	No	IHS' response to its management deficiencies has been to reissue its manual chapter on management control. DHHS has an overall strategy for a Unified Financial Management System (UFMS), so IHS is limited in making investments in its internal financial systems since they may impact on UFMS implementation.	IHS' current management control inventory includes 28 systems that are subject to annual assessment and reports.	10%	0.0
Total Section Score					**100%**	**60%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Large Extent	IHS has demonstrated reductions in the YPLL rate and increase in rates of "ideal" blood sugar control for AI/AN diabetics. The goal to decrease obesity rates in AI/AN children is a new measure so there is no reported performance. As mentioned above, IHS is also developing a new measure to address obesity in the overall AI/AN population through the ITU Obesity Coordinating Committee.		20%	0.1

Long-Term Goal I:	Decrease Years Productive Life Lost in AI/AN
Target:	20% decrease by 2010 (baseline to be developed by October 2003)
Actual Progress achieved toward goal:	1973-1995: reduced by 50%; 1987-89 - 1996-98: reduced by 19%
Long-Term Goal II:	Increase "ideal" blood sugar control in AI/AN diabetics
Target:	40% of AI/AN diabetics achieve "ideal" control by 2010
Actual Progress achieved toward goal:	FY 98: 22%; FY 99: 24%; FY 00: 26%; FY 01: 30%
Long-Term Goal III:	Decrease obesity rates in AI/AN children (2-5 years)
Target:	20% by 2010 (baseline to be developed by October 2003)
Actual Progress achieved toward goal:	New measure

2	*Does the program (including program partners) achieve its annual performance goals?*	Large Extent	IHS has increased rates of "ideal" blood sugar control for AI/AN diabetics and achieved 14 of the 15 performance goals supporting the YPLL including the key performance goal: reduce unintentional injury mortality rates. A performance target for decreasing obesity in AI/AN children will not be set until FY 2006.		20%	0.1

Key Goal I:	Reduce unintentional injury mortality rates for AI/AN people
Performance Target:	FY 99: 95.8/100,000
Actual Performance:	FY 99: 99.5
Key Goal II:	Increase "ideal" blood sugar control in AI/AN diabetics
Performance Target:	FY 01: Improve from FY 00 (26%)
Actual Performance:	FY 01: 30%
Key Goal III:	Decrease obesity in AI/AN children (ages 2-5)
Performance Target:	To be established in FY 2006
Actual Performance:	New measure

3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Large Extent	As mentioned above, IHS has achieved cost effectiveness in its rate agreements with frequently contracted providers resulting in savings of $182.5 million in FY 2001. In addition, as mentioned above, IHS has been successful in meeting its performance goals. These performance goals have been achieved with level funding and modest increases in local service units workforce and decreases in Area and Headquarters staff.	IHS local service units workforce increased by 1,530 (13%) from 1993-2001. IHS Headquarters workforce declined by 549 (59%) and the Area office workforce declined by 1,573 (58%) over the same period. This is a net decrease of 592 employees. Outpatient visits have increased by 50% since 1990. Improved performance on goals, annual in particular, should result in a "Yes".	20%	0.1
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Large Extent	IHS compares favorably to other Federal programs that provide direct health care services included in the health common measures exercise: Defense, Veterans Affairs and Community Health Centers.	For FY 2001, IHS had the second lowest cost measure (total revenue per unique patient user) at $2,721; the third highest efficiency measure (annual outpatient appointment per provider FTE) at 2,955; and the highest quality measure (percentage of diabetics who received the blood sugar test (HbA1c) in the past year) at 95%.	20%	0.1
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Yes	As mentioned above, IHS' hospital and ambulatory facilities received average scores of 91 and 93 (out of 100), respectively, in evaluations of management, patient care, etc. All IHS-operated facilities maintained accreditation.	Section II, Question 5.	20%	0.2
Total Section Score					**100%**	**74%**

OMB Program Assessment Rating Tool (PART)

Capital Assets & Service Acquisition Programs

Name of Program: IHS Sanitation Facilities Construction Program

Section I: Program Purpose & Design (Yes,No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The purpose of the Indian Health Service (IHS) Sanitation Facilities Construction (SFC) program is to provide sanitation facilities to American Indian/Alaska Native (AI/AN) homes and communities.	P.L. 86-121 (42 USC 2004a) the Indian Sanitation Facilities Act created the SFC program in 1959. This legislation authorizes the SFC program to provide essential water supply, and liquid and solid waste disposal facilities to AI/AN homes and communities. This authority was reaffirmed by Congress in the 1988 Amendments to P.L. 94-437 (25 USC 1632), the Indian Health Care Improvement Act (IHCIA), as amended.	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The provision of sanitation facilities is an extension of IHS' primary health care delivery efforts. The availability of essential sanitation facilities can be a major factor in preventing waterborne communicable disease episodes. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts.	Over 18,000 AI/AN homes do not have water and sewer facilities meeting the Safe Drinking Water Act and Cleanwater Act. An additional 13,000 AI/AN homes do not have either water or sewer facilities. This constitutes approximately 11% of the AI/AN homes inventoried in the Sanitation Deficiency System (SDS). Over 21,000 AI/AN homes do not have a source of potable water. There are also an additional 119,000 homes which lack either adequate water supply, sewage disposal and/or solid waste facilities.	20%	0.2

3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	SFC projects fall into two major categories: regular projects to serve existing homes; and housing funds to serve new and like new homes. The regular funding is prioritized for allocation based on several rating criteria including health impact, deficiency level, economic feasibility ,tribal priority, outside contributions, first service and operation and maintenance (O&M) capability. This priority system allows IHS to balance health needs with economic feasibility. Housing funds are distributed to serve new and like new (renovated) homes; the former have priority over the latter.	The regular and housing projects account for approximately 98% of the appropriated funds with the remainder being spent for special and emergency requests. Additionally, the program, due to the unique authority provided under 42 USC 2004a is able to leverage and utilize funding from States, Federal agencies and Tribes to construct sanitation facilities. In 2001, an additional 47% in outside contributions was added to the appropriated funding to further the purpose of the program to complete SFC projects.	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	The SFC program is the primary provider of sanitation facilities to the AI/AN population (members of recognized tribes and need are the bases for eligibility and the entire project cost is funded by IHS). IHS provides service to new homes, service to existing homes, sanitation system expansions, new systems (first time service), combination water/sewer projects and facility upgrades. SFC provides engineering planning, design and construction/project management services. EPA and Agriculture's Rural Utility Service (RUS) only provide funding for water and sewer facilities (i.e. not to homes). EPA has water project grants and sewer project grants to upgrade facilities only for existing homes. RUS has a loan component.	The SFC FY 2001 appropriation of $94 million is provided for service specifically to the AI/AN population, other Federal, state or local programs are funded to serve the general population. In FY 2001, the SFC program received outside contributions of approximately $44 million from other Federal agencies, States and Tribes. The majority of these contributions were from RUS and EPA. Interior's Bureau of Reclamation (BOR) funding is limited to only rural water and can fund systems for the provision of agricultural water, which is not an authorized use of IHS SFC resources.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	Since, 1960, SFC program funding has served 249,000 AI/AN homes with the completion of projects through FY 2001. However, as mentioned above, the problem persists. For example, approximately 1% of all U.S. homes lack safe water, while 7.5% of AI/AN homes lack safe water. Given the economic conditions on reservations, it is unlikely that grants, loans, or tax incentives would be successful alternatives to the current program.	The SFC program is considered to be optimally designed by other programs. The EPA Clean Water (CWA) and Safe Drinking Water (SDWA) programs use the SFC priority system and also prefer that IHS administer projects because of the inherent efficiencies in the program. See EPA CWA regulations and SDWA Guidelines.	20%	0.2
Total Section Score					**100%**	**100%**

Section II: Strategic Planning (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	The IHCIA contains a statutory long term goal "..that all Indian Communities and Indian homes, new and existing, be provided with safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible." The IHS Strategic Plan states a specific long-term SFC goal to increase the percentage of AI/AN homes with potable water.	In addition to the statutory goal of 100% of A/AN communities and homes with safe and adequate water supply and sanitary sewage disposal, IHS has the following long-term goals: (1) Increase the number of AI/AN homes with sanitation facilities from 92.5% to 94% by 2010; and (2) Increase the percentage of Deficiency Level 4 or 5 AI/AN homes (as defined by 25 U.S.C. 1632) served by the SFC program (percentage target and year to be developed by October 2003).	12%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	IHS has a limited number of annual goals that demonstrate progress toward achieving the long-term goals.	(1) Provide sanitation facilities to serve new or like-new AI/AN homes and existing AI/AN homes; and (2) Percentage of AI/AN homes served by SFC program funding for the backlog of existing AI/AN homes will be at Deficiency Level 4 or 5 (as defined by 25 USC 1632) (percentage target to be developed by October 2003).	12%	0.1
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	The primary SFC program partners are the Tribes, including those that have assumed the program through ISDA agreements. The Tribes and SFC staff report on performance semiannually though the SFC Project Data System (PDS) which tracks progress and status of funded projects from project document execution through final report. Additionally all SFC program staff and Tribal program staff collect and report on needs through the Sanitation Deficiency System (SDS) which involves Tribal consultation. In addition, Tribes, IHS, EPA, utilities, housing authorities and other partners enter into MOA's and transfer Agreements for each project.	Data on all Tribes and Tribal communities is contained within the SFC PDS and SDS data systems that are mandated by 25 USC 1632 and are the basis for collecting the needs based information for budget justification and funding allocation. Published SFC Project Final Reports contain copies of Memorandum of Agreements (MOA) and Transfer Agreements signed by all involved partners.	12%	0.1
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	The SFC program collaborates with RUS, BOR, Housing and Urban Development (HUD) and EPA in addition to State and Tribal programs in the funding and development of SFC projects These agencies also are involved in an Interagency taskforce that awards project funds for Tribal solid waste projects annually. All involved parties enter into MOAs for each project identifying participation, coordination and responsibility of each partner.	In 2001, the SFC program received $44 million in funds from Federal agencies to administer joint projects. A similar amount was administered directly by Tribes with technical assistance and design services provided by SFC.	12%	0.1

5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	No	No independent, objective quality evaluations of the SFC are conducted. There is an annual management control review completed by the Area Directors on the SFC program and project partners (EPA, BOR, RUS, HUD, etc.) enter into MOA and Transfer Agreements to confirm scope and completion status of projects.		12%	0.0
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	Yes	The SFC program is able to show the impact of funding policy and legislative changes on performance.	The SFC performance goal is able to show the number of homes that can be served at a specific funding level.	12%	0.1
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	No	There is no evidence that the program has taken meaningful steps to address its strategic planning deficiencies. No independent, quality evaluations of the SFC program have been undertaken in recent years and none are scheduled.		5%	0.0

8 (Cap 1.)	*Are acquisition program plans adjusted in response to performance data and changing conditions?*	Yes	All SFC projects contain contingency funds. If changing conditions are found, projects are adjusted through a formal amendment or modification process. If a project will exceed established cost thresholds, it can be cancelled and the funds allocated for a new project. This is typically due to cost associated with impacts identified in the environmental review process, or if unforeseen site conditions found in the testing/construction phase. Many Areas use planning agreements to do preconstruction activities such as well drilling, Environmental Reviews and testing programs. A small portion of the SFC budget is reserved for emergency projects such as fire, flood damage, etc.	Published SFC Project Final Reports show the project's proposed budget, actual cost and include an explanation for any differences. Final Reports contain copies of Project Summaries showing contingency funding as a separate project budget line item. Project files contain construction logs, weekly or daily construction reports, construction schedules and commitment registers.	12%	0.1
9 (Cap 2.)	*Has the agency/program conducted a recent, meaningful, credible analysis of alternatives that includes trade-offs between cost, schedule and performance goals?*	Yes	Alternatives are reviewed for each SFC project. This is conducted in the feasibility stage. The environmental review process required by the National Environmental Policy Act (NEPA) includes an analysis of alternatives. SFC is also able to utilize several alternative methods of procurement/construction including FAR Government Contracting, Government Force Account, 638 contracting, MOA contracting and MOA force account based on individual project/Tribal needs.	All proposed projects are analyzed for established cost thresholds. Alternatives must be reviewed for compliance with SDWA, CWA and local requirements. SDS includes criteria for facilities maintenance requirements, local capacity for O&M, as well as the long term O&M costs of the facility. Project Summary documents include Method of Construction section, NEPA Review section and many address Alternatives Considered (as appropriate).	12%	0.1
Total Section Score					**100%**	**83%**

Section III: Program Management (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	The SFC program regularly collects timely and credible performance information through its PDS and SDS systems. Projects are ranked in the system based on assigned scores for the following criteria: Health; Deficiency Level; Previous Services; Contribution; Capital Cost; O&M Capability; Tribe Priority; Local Conditions (Area Director discretion to reduce score for any documented reason). At the Area level, projects are funded in priority order from SDS.	Housing funds (new and like new homes) are allocated based on the request from each area. Each Area receives 90% of the prior year's level (unless less is requested) because the requests for housing funds are relatively even throughout the Areas and exceed appropriated funds. The remaining 10% of housing funds is then allocated pro-rata based on the total request. Regular funds (upgrades) are distributed to Areas based entirely on the SDS data.	11%	0.1

2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	Federal managers and program partners are held accountable for cost, schedule and performance results.	The Area Directors make the final allocation decision based on the recommendations of the SFC and Office of Environmental Health and Engineering Support (OEHE). The Area Directors are evaluated based on SFC program performance in their performance plans with the IHS Director. Accountability for Tribes varies based on the instrument and method chosen to accomplish the work. If the project is performed as a direct service through a FAR contract, the contractor is accountable to the full extent required by the FAR. If the Tribe is performing the work through an MOA, performance and accountability provisions are passed on through the MOA, which is typically governed by common law provisions. If the work is accomplished through an ISDA construction contract, the Tribe assumes complete responsibility for the project and project completion, though payment is based on project schedules and progress. Each project has a schedule within PDS.	11%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	All appropriated funds are obligated by MOA in the year received, and contributed funds are generally obligated upon receipt. Project funds administered by the SFC are spent for the intended purpose	In addition, IHS funds remaining at the end of a project are transferred to another SFC project; unexpended contributed funds are returned to the contributor. Contributed funding requires financial reporting on behalf of the SFC program. Also, Single Agency Audits of ISDA construction contracts have not included findings that SFC program funds have been spent for anything other than intended purposes.	11%	0.1

4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	The SFC program has incentives and procedures to measure and achieve efficiencies in program execution dependent upon the instrument. In addition, two efficiency measures have been developed for the Rural Water Common Measures exercise which the SFC program is included: (1) Number of water connections per million dollars; (2) Population served per million dollars.	The SFC is able to utilize several different methods to achieve efficiencies in procurement/construction: competitive FAR contracts; Government or MOA Force Account (which is on a non-profit reimbursable basis). Under an MOA, a Tribe may use a procurement process utilizing competitive bids. Under ISDA contracts, Tribes have the same methods available to administer the program. Historical construction costs, means estimated cost (industry standard), Engineers Estimates, and Bid Abstracts are used for cost comparisons.	11%	0.1
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	Yes	The authority granted to Tribes by the Indian Self-Determination Act (ISDA) to assume control of their health care delivery system through contracting requires that IHS be able to transfer the full program costs, including administrative costs and allocated overhead. Consequently, IHS tracks the program costs for contracted and retained funds in the headquarters and area offices.	In addition, SFC project budgets are based on estimated costs including indirect and direct costs, contingencies and include inflation to account for project duration.	11%	0.1
6	*Does the program use strong financial management practices?*	Yes	Each SFC field program and area program office maintains general ledgers and conducts daily reconciliation of project expenditures in the system and with the Financial Management Branch staff.	There are no material weaknesses in the audited financial statements related to SFC. Also, Final Reports produced by the SFC document funding reconciliation.	11%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	N/A			0%	

8 (Cap 1.)	*Does the program define the required quality, capability, and performance objectives of deliverables?*	Yes	SFC project designs are based on value engineering, the requirement to meet CWA and/or SDWA and local regulations. Long term costs and ability to provide O&M are analyzed as well as the life cycle of the proposed facilities. The program provides technical assistance and extensive training on O&M. SFC design parameters have been developed to provide the most cost-effective and maintenance-free facilities possible. Project Summaries and MOAs all state that minimum IHS standards must be utilized for projects. All SFC projects are under direct supervision of a Licensed Engineer.	The SFC program's objective is to provide relatively low maintenance and easy to operate facilities.	11%	0.1
9 (Cap 2.)	*Has the program established appropriate, credible, cost and schedule goals?*	Yes	Each SFC program area has developed cost estimates criteria and uses bid abstract information, cost accounting data, and/or industry standard methods for determining cost estimates and schedules.	SFC has established allowable cost thresholds. PDS and SDS allows for monitoring program wide construction costs and schedules. The most difficult cost and schedule item to estimate is the impact of the National Environmental Policy Act and the National Historic Preservation Act review process which can stall a project indefinitely.	11%	0.1
10 (Cap 3.)	*Has the program conducted a recent, credible, cost-benefit analysis that shows a net benefit?*	No	The SFC program has not been subjected to a recent credible, cost-benefit analysis that shows a net benefit.	The most recent, credible cost-benefit analysis available was a March 11, 1974 Comptroller General Report to Congress. Other documents reviewed were not specific to the SFC program but showed the health care savings for every dollar spent on sanitation facilities.	11%	0.0
11 (Cap 4.)	*Does the program have a comprehensive strategy for risk management that appropriately shares risk between the government and contractor?*	N/A	The Federal government does not acquire an asset with the SFC program. The facilities are owned by the Tribe which is responsible for operation and maintenance.		0%	
Total Section Score					**100%**	**89%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Large Extent	To a large extent, the SFC program is demonstrating progress in achieving its long-term outcome goal. The program is also developing a measure to increase the percentage of Deficiency Level 4 or 5 AI/AN homes served. These homes are the most deficient homes in the IHS inventory with respect to the lack of sanitation facilities.	From 1959 through 1998 over 9,100 sanitation projects provided water supply and wastewater disposal facilities to over 230,000 Indian homes. Only 20% of AI/AN homes had sanitation facilities in 1959; currently, 92.5% have a safe water supply in the home. In addition, rates for infant mortality, goastroenteritis and other environmentally related diseases have been reduced by approximately 80% since 1973.	17%	0.1

Long-Term Goal I:	To increase the number of AI/AN homes with sanitation facilities
Target:	94% by 2010
Actual Progress achieved toward goal:	Only 20% of AI/AN homes had sanitation facilities in 1959; currently, 92.5% have a safe water supply in the home.
Long-Term Goal II:	Increase the percentage of Deficiency Level 4 or 5 AI/AN homes (as defined by 25 U.S.C. 1632) served by the SFC program
Target:	To be developed by October 2003
Actual Progress achieved toward goal:	New measure
Long-Term Goal III:	
Target:	
Actual Progress achieved toward goal:	

2	*Does the program (including program partners) achieve its annual performance goals?*	Large Extent	The SFC program continually exceeds its annual targets for providing sanitation facilities to serve new or like-new AI/AN homes and existing AI/AN homes. Actual AI/AN homes served tend to exceed those in project proposals due to relocation to area served, lower actual costs, etc. The program should be more aggressive in setting its annual targets. The SFC program is also developing a new goal to capture activity along deficiency levels.	The SFC program exceeded its annual target for FY 2001 (14,730) by 3,272 homes, FY 2000 target (14,775) by 3,601 homes, and FY 1999 target (15,230) by 1,341 homes.	17%	0.1

Key Goal I:	Provide sanitation facilities to serve new or like-new AI/AN homes and existing AI/AN homes
Performance Target:	FY 01: Serve 14,730 new or like-new and existing AIAN homes
Actual Performance:	FY 99: 16,571; FY 00: 18,376; FY 01: 18,002
Key Goal II:	Percentage of AI/AN homes served by SFC program funding for existing AI/AN homes will be at Deficiency Level 4 or 5
Performance Target:	To be developed by October 2003
Actual Performance:	New measure
Key Goal III:	
Performance Target:	

	Actual Performance:					
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Yes	The SFC program has been able to demonstrate improved efficiences and cost effectiveness in achieving its program goals. The cumulative average construction cost per home has decreased since FY 1995. In addition, as mentioned above, IHS' contracting methods such as open-market fixed price contracts (competition with contractor assumption of risk) and Force Account (non-profit with cost controls dictated through the Memorandum of Agreement, assist in achieving cost control. The SFC program has established a feasible cost threshold based on a combined application of HUD and IHS construction indexes for each State since 1988.	The cumulative average cost per home has decreased from over $5,700 in FY 1995 to FY 2000 and 2001. This decrease has occurred amidst a 2% average rate of construction inflation from December 1992 to December 2001 according to the U.S. Department of Labor, Bureau of Labor Statistics, Producer Price Index Revision for Construction Industries.	17%	0.2
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Large Extent	The SFC program is included in the Rural Water common measures exercise with RUS, BOR, and EPA. RUS and EPA provide grants and loans for rural water projects and SFC and BOR provide funding and construction management for rural water projects. BOR is authorized to fund rural water projects for agricultural and industrial projects whereas IHS serves AI/AN homes only. Despite the differences in the types of projects the SFC and BOR programs fund and construct, these two programs activities are the most comparable of the programs in the common measures exercise. An analysis of the measures shows that the SFC program compares favorably; particularly with respect to the BOR program.	In FY 2001, the SFC program had 174 water connections per million dollars in the East and 212 water connections per million dollars in the West. BOR did not have any activity in the East and had 24 water connections per million dollars in the West. Also, in FY 2001, the SFC program served 766 people per million dollars in the East and 933 people per million dollars in the West. BOR served 123 people per million in the West and had no activity in the East. The differences in the SFC and BOR measures is influenced by the relatively large scale projects of the latter. It is also necessary to note that the SFC program's funding in FY 2001 ($76.18 million) exceeded BOR's ($58.9 million) by $17.2 million.	17%	0.1
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	No	No independent, quality evaluations of this program have been undertaken in recent years.	As mentioned above, the most recent, independent analysis of the SFC program is the March 11, 1974 Comptroller General Report to Congress.	17%	0.0

6 (Cap 1.)	*Were program goals achieved within budgeted costs and established schedules?*	Yes	As mentioned above, annual goals were surpassed and the projects were completed within budget and within the time frames established in existing guidelines.	All SFC projects are completed within a four-year time frame and are typically completed within budget. There has never been an antideficiency issue in the SFC program.	17%	0.2
Total Section Score					**100%**	**67%**

Program Assessment Rating Tool (PART)

Program: Low Income Home Energy Assistance Program
Agency: Department of Health and Human Services
Bureau: Office of Community Services, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	25%	78%	8%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The program assists low income households, particularly those with the lowest incomes, that pay a high proportion of household income for home energy, primarily in meeting their immediate home energy needs.

Evidence: Sections 2602(a) and 2603(4) of the LIHEAP statute (Title III, P.L. 105-285); Conference Report accompanying S. 2000; House Report accompanying HR 4250

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: LIHEAP targets 2 groups: (1) high-energy burden households, which are households with the lowest incomes and highest home energy costs, and (2) vulnerable households, which consist of frail older individuals, individuals with disabilities, or very young children. Home energy burden for low income households is over four times that of non-low income households-- putting them in danger of safety hazards. Vulnerable households are at risk for health problems due to insufficient home heating or cooling.

Evidence: Section 2603(4) and 2605(b)(1)(A-C) of the LIHEAP statute; Senate Report 103-251 accompanying S. 2000; LIHEAP Home Energy Notebook (Figure 3, p.iii).

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: LIHEAP is the only comprehensive national energy assistance program as it includes heating and cooling assistance, and energy crisis intervention. Grantees may use LIHEAP funds for low-cost residential weatherization and other energy-related home repair, similar to the DOE Weatherization Assistance Program (WAP). However, WAP doesnt serve tribes and territories directly.

Evidence: LIHEAP Committee on Managing for Results workbook, Integrating Government-Funded and Ratepayer-Funded Low-Income Fuel Assistance Programs (May 2002); "An Introduction to Electric Utility Restructuring" (Eisenberg, Sept 1997)

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: NO Question Weight: 20%

Explanation: The current formula includes factors related to energy expenditures, low-income populations and climate and favors Northeast and Midwest states. The revised LIHEAP formula distributes funds according to each states share of expenditures by low income households for home energy-- however it is implemented only when appropriations go above $1.975 billion in a given year, which has occurred twice since it was established. The statute for this formula provides for "hold-harmless provisions", in which no grantee is to get less under the new formula than they received under the old formula with an appropriation of $1.975 billion. The new formula gives more weight to warm weather, which means that Southern and Western states fair better when the new formula is activated than they do under the current.

Evidence: Conf. Report accompanying S. 2000 (103-251); House Report accompanying H.R. 4250; LIHEAP Reconsidered by Mark J. Kaiser and Allan G. Pulsipher, Center for Energy Studies, Louisiana State University

Program ID: 10001059

Program Assessment Rating Tool (PART)

Program: Low Income Home Energy Assistance Program
Agency: Department of Health and Human Services
Bureau: Office of Community Services, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	25%	78%	8%	

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: LIHEAP's GPRA plan tracks and insures that resources reach intended beneficiaries; the measures specificially focus on targeting vulnerable and high energy burden households. In addition, the LIHEAP statute provides contingency funds which are targeted to those states, territories and tribes most affected by an emergency.

Evidence: GPRA Performance Plan; LIHEAP Report to Congress for FY 2001; History of LIHEAP Contingency Fund Distributions; Sec 2602(e) of the LIHEAP statute; Block Grant Regs

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: NO Question Weight: 12%

Explanation: The program has recently developed measures that are proxies for health and safety outcomes. These long-term measures focus on targeting assistance. The program has also identified other goals that are more difficult to measure, but are goals nonetheless. These include: (1) increasing energy affordability and (2) increasing efficiency of energy usage of low income households (measured by the Department of Energy).

Evidence: Sec. 2605(b) of the LIHEAP statute and LIHEAP IM96-02; LIHEAP Household Report; ACF GPRA Report

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: NO Question Weight: 12%

Explanation: The LIHEAP program projects that the rate for LIHEAP eligible elderly households served will be at least equal to that of all LIHEAP eligible households by FY 2008, despite the inherent difficulties of serving this population. The program seeks to maintain the percentage of households served with young children. Because these measures are relatively new and a trend has not yet been established, it cannot yet be determined if these measures are ambitious.

Evidence: ACF GPRA Reports

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: YES Question Weight: 12%

Explanation: OCS has developed targeting indexes for households with elderly and young children as annual performance measures. Targeting indexes are not calculated for households with a disabled member as States define disability differently. As aforementioned, these goals are relatively new and show some progress toward achieving the long term goals.

Evidence: ACF's LIHEAP GPRA report for targeting index data; FY 2001 LIHEAP Home Energy Notebook

2.4 Does the program have baselines and ambitious targets for its annual measures? Answer: NO Question Weight: 12%

Explanation: Baseline data are available on targeting indexes for low income elderly and young children households. The target is to increase by 2 index points annually the rate for low income eligible elderly households receiving heating assitance by FY 2008. Because these measures are relatively new and a trend has not yet been established, it cannot yet be determined if these measures are ambitious.

Evidence: ACF's LIHEAP GPRA report for targeting index data.

Program ID: 10001059

Program: Low Income Home Energy Assistance Program
Agency: Department of Health and Human Services
Bureau: Office of Community Services, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	25%	78%	8%	

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: Most states have not developed long-term goals for their programs, nor are they required to do so under the block grant structure. However, each State files an annual LIHEAP program plan that documents how the state will meet the unique needs of its low-income households. States must conduct outreach activities and can give priority to households with highest home energy needs. In addition, OCS established the LIHEAP Managing for Results Committee in 1998 which is composed mostly of state LIHEAP directors and seeks to support performance measurement and evaluation efforts.

Evidence: LIHEAP Model Plan and Assurances; Charter of LIHEAP Managing for Results Committee; LIHEAP Household Report; Section 2605 (b) of the LIHEAP statute.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: NO Question Weight: 12%

Explanation: There has been no national studies conducted to evaluate program effectiveness and improvement. An evaluation is being planned concerning the targeting of high energy burden households.

Evidence: LIHEAP Home Energy Notebook for FY 2001. LIHEAP Report to Congress for FY 2001. ACF's GPRA report

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: The program's budget is not performance-based. OCS has developed estimates of the amount of fuel assistance funding needed to reduce the home energy burden for all low income households to 10% and 5% of household income. However, the additional funding needed in reducing home energy burden to a certain level would require that the program be changed from a block grant to an entitlement program.

Evidence: LIHEAP Home Energy Notebook for FY 2001

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: NO Question Weight: 12%

Explanation: The Office of Community Services (OCS) is undergoing a restructuring process to better address the needs of all OCS programs, including LIHEAP. It is projected that this process will help eliminate duplication and redirect limited resources, in order to set ambitious program results, however the plan has not yet been implemented and it is not clear how LIHEAP-specific planning deficiencies will be addressed.

Evidence: OCS Restructuring Plan (to be published in the Federal Register)

Program ID: 10001059

Program Assessment Rating Tool (PART)

Program: Low Income Home Energy Assistance Program
Agency: Department of Health and Human Services
Bureau: Office of Community Services, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	25%	78%	8%	Results Not Demonstrated

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 11%

Explanation: OCS collects annual performance data from grantees and a sample of LIHEAP recipients through the Current Population Survey and the Residential Energy Consumption Survey. OCS analyzes the targeting indexes for vulnerable households by Census division to identify those areas where eligible vulnerable households are underserved. For those underserved locations, OCS concentrates LIHEAP outreach efforts by coordinating with local programs funded by Head Start, the Administration on Developmental Disabilities and the Administration on Aging.

Evidence: LIHEAP Report to Congress for FY 2001; LIHEAP Energy Notebook for FY 2001; LIHEAP Household Report; LIHEAP Grantee Survey; OCS Restructuring Plan (to be published in the Federal Register)

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 11%

Explanation: Federal managers are held accountable through annual work plans and individual performance plans. LIHEAP grantees are held accountable for program performance through annual financial audits, State Plan Assurances, reports on performance data, and on administrative cost limits.

Evidence: ACF Manager Work Plans; ACF Employee Performance Management System (EPMS); Single Audit Act; LIHEAP Report to Congress for FY 2001; Section 2605(b) of the LIHEAP statute

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: YES Question Weight: 11%

Explanation: Once LIHEAP grantee plans are completed, and federal funds are available, grant awards are issued immediately. States receive quarterly allocations of their annual allotments. States must obligate at least 90% of their fiscal year allocation before the end of that fiscal year on 9/30, and may carryover no more than 10% into the following fiscal year.

Evidence: LIHEAP statute: Section 2607; Regs: CFR 96.81; Carryover and Reallotment Report; Quarterly Estimate Report, ACF-535; SF 269-A, Financial Status Report

Program: Low Income Home Energy Assistance Program
Agency: Department of Health and Human Services
Bureau: Office of Community Services, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	
80%	25%	78%	8%	Results Not Demonstrated

3.4 **Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: NO Question Weight: 11%

Explanation: An efficiency is under development. Currently, the program has incentives to improve cost effectiveness. The LIHEAP leveraging incentive program awards grantees that have acquired additional non-Federal energy assistance resources to expand the effect of the Federal LIHEAP dollars. For example, grantees can report the following activities as countable resources under this program: home energy discounts or waivers; forgiveness of energy arrearages; waiver of utility connection fees and donated weatherization materials. Finally, OCS is developing an integrated MIS system to increase the availability of data on-line and streamline reporting activities. These IT improvements will provide an efficient and effective use of automation to meet program goals and objectives.

Evidence: LIHEAP Report to Congress for FY 2001. State electronic reporting templates for LIHEAP Household Report and LIHEAP Grantee Survey. OCS MIS as part of OCS Restructuring Plan (to be published in the Federal Register)

3.5 **Does the program collaborate and coordinate effectively with related programs?** Answer: YES Question Weight: 11%

Explanation: LIHEAP coordinates with DOE's Weatherization Program to allow flexibility for LIHEAP grantees to use DOE, LIHEAP or a combination of each program's rules. OCS LIHEAP Managing for Results Committee is a partnership among states, the National Energy Assistance Directors Association and other entities; OCS also partners with Head Start, Administration on Aging and Administration on Developmental Disabilities. States are required to coordinate under statutory assurances.

Evidence: LIHEAP Weatherization Information Memorandum; LIHEAP Leveraging Incentive Information Memorandum; Section 2605(b)(4) of the LIHEAP statute; Charter of LIHEAP Managing for Results Committee.

3.6 **Does the program use strong financial management practices?** Answer: YES Question Weight: 11%

Explanation: States must comply with the Single Audit Act requirements. States must submit a financial status report each year on how LIHEAP funds are used. Grantees are required to have provisions in place to prevent waste, fraud and abuse, and have systems to track the accounting of funds.

Evidence: OMB Circular A-128; Section 2605(b)(10) of the LIHEAP Statute; Block Grant Regs: 96.87; 96.30; SF 269-A, Financial Status Report

3.7 **Has the program taken meaningful steps to address its management deficiencies?** Answer: NO Question Weight: 11%

Explanation: OCS is undergoing a restructuring process to ensure that management resources are in place to meet the needs of the administration and grantees, however it has not yet been implemented. Specific program effects on LIHEAP management deficiencies are not yet known.

Evidence: OCS restructuring plan (to be published in the Federal Register)

3.BF1 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: YES Question Weight: 11%

Explanation: An annual review of grantees LIHEAP plan applications is conducted to determine program completeness, with a check to determine compliance with the LIHEAP statute. LIHEAP program staff conduct compliance reviews of states and, in turn, states monitor local agency compliance with the law.

Evidence: Annual state LIHEAP plans, Section 2605 of the LIHEAP statute; OCS/LIHEAP Compliance Review Monitoring Instrument

Program Assessment Rating Tool (PART)

Program: Low Income Home Energy Assistance Program
Agency: Department of Health and Human Services
Bureau: Office of Community Services, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	25%	78%	8%	

3.BF2 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: YES Question Weight: 11%

Explanation: The program collects detailed LIHEAP caseload and fiscal data from grantees and makes the data available through the the LIHEAP Report to Congress (the public can attain the executive summary on the website and request the full report). The LIHEAP Clearinghouse Website provides detailed program characteristics and state plans, however performance data is not available due to limited resources.

Evidence: LIHEAP Report to Congress for FY 2001; LIHEAP Household Report; LIHEAP Grantee Survey; http://www.acf.dhhs.gov/programs/liheap/execsum.htm (Annual Report); http://www.ncat.org/liheap/ (Other data)

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: NO Question Weight: 25%

Explanation: Long-term performance goals are being developed. Trend data shows that the net effect of LIHEAP assistance has been to move low income household heating burdens closer to that of all households. Findings suggest that households with low incomes and high energy costs are receiving help from LIHEAP.

Evidence: LIHEAP Report to Congress for FY 2001. LIHEAP Energy Notebook for FY 2001

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: NO Question Weight: 25%

Explanation: Baseline data have been collected on the targeting of LIHEAP assistance to vulnerable households. However, the program has recently established new targets for its annual performance measures. FY04 wil be the first year they will receive data that reveals the impact of new outreach efforts.

Evidence: LIHEAP GPRA Reports; Report: "Accountability for Block Grants" issued to President's Council on Integrity and Efficiency (Feb 2002)

4.3 **Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: LIHEAP does not measure cost-effectiveness. However, leveraging funds are awarded to LIHEAP grantees that use their own or other non-federal resources to expand effect of Federal LIHEAP dollars. In FY 2002, $27.5 million was earmarked for levearging incentive grant awards. In addition, OCS is undergoing a restructuring process that is designed to better serve the administration and grantees.

Evidence: OCS restructuring (TBA Fed Register); LIHEAP IM-2002-14

4.4 **Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?** Answer: NA Question Weight: 0%

Explanation: There are no similar national programs that provide comprehensive energy assistance services.

Evidence: Oak Ridge Report: "Weatherization Works: Final Report of the National Weatherization Evaluation" (Sept 94)

Program ID: 10001059

Program Assessment Rating Tool (PART)

Program: Low Income Home Energy Assistance Program
Agency: Department of Health and Human Services
Bureau: Office of Community Services, ACF
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
80%	25%	78%	8%	

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?

Answer: NO Question Weight: 25%

Explanation: No national performance evaluations have been conducted.

Evidence: GPRA Reports

Program ID: 10001059

PART Performance Measurements

Program: Low Income Home Energy Assistance Program

Agency: Department of Health and Human Services

Bureau: Office of Community Services, ACF

Measure: Increase the targeting index of LIHEAP recipient households having at least one member 60 years or older compared to non-vulnerable LIHEAP recipient households (2004 targets are under development)

Additional Information: The recipiency targeting index for a specific group of households is computed by comparing the percent of an eligible target group that received LIHEAP benefits to the percent of all eligible households that received LIHEAP benefits. A targeting index of 100 indicates that a group of LIHEAP eligible households were served at the same rate as all LIHEAP eligible households. For FY 2001, the targeting index of LIHEAP eligible elderly households that were served was 90. This indicates that LIHEAP eligiible elderly households were served at a 10 percent lower rate than all LIHEAP eligible households.

Year	Target	Actual	**Measure Term:** Annual
2001	Baseline	90	
2002	90:64	91:72	

Measure: Increase the targeting index of LIHEAP recipient households having at least one member 5 years or younger compared to non-vulnerable LIHEAP recipient households (2004 targets are under development)

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2001	Baseline	109:64	
2002	109:64	110:72	

Measure: Increase the amount of non-Federal energy assistance resources leveraged through the LIHEAP leveraging incentive program (Developmental)

Additional Information:

Year	Target	Actual	**Measure Term:** Annual (Efficiency Measure)
2003			

OMB Program Assessment Rating Tool (PART)

Block/Formula Grants

Name of Program: Maternal and Child Health Block Grant (MCHBG)

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The purpose and mission of the MCH Block Grant is to improve the health of all mothers, children, and their families by: 1) assuring access to quality care, 2) reducing infant mortality and the incidence of preventable diseases, 3) providing prenatal and postnatal care to women, 4) increasing the number of children receiving health assessments, 5) implementing community-based, family-centered care for children with special health care needs, and 6) providing assistance to mothers for services.	Title V of the Social Security Act authorizes this program and clearly states the purpose of the program. In addition, the mission of the MCH Block Grant is included in the HRSA and MCH Bureau Strategic Plans, as well as the Congressional Justification.	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The MCH Block Grant is a safety net program for low-income, at risk pregnant women; children with special health care needs; the uninsured; and the underinsured. Nearly 12 percent of all children were uninsured in 2000, thus causing increased demand for MCH Block Grant services. In addition, disparities in health indicators often leads to MCH Block Grant funds being used to address health disparities in certain underserved communities.	HRSA FY 2003 Congressional Justification and GPRA Plan.	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The MCH Block Grant is the payer of last resort. It is the only Federal program that focuses on improving the health of all mothers and children, in particular assisting the underinsured and uninsured. The MCH Block Grant operates in partnership with State MCH and Children with Special Health Care Needs programs.	Title V of the Social Security Act requires $3 of every $4 Federal dollars to be matched by states (http://www.mchdata.net).	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	Activities funded under the MCH Block Grant tend to work in tandem with other similar efforts. Without these resources and the required state match, there would be a substantial decrease in available resources and systems to care for vulnerable populations. This, in effect, would likely cause: 1) increases in infant mortality, 2) increases in the incidence of preventable handicapping conditions among these populations, and 3) decreased children appropriately immunized.	Between 1995 and 2000, the number of children served by Title V increased from 20.2 million to 22.8 million, the percentage of children with special health care needs with a source of insurance for primary and specialty care increased from 83 percent to 90.3 percent, and the percent of infants born to pregnant women who received prenatal care beginning in the first trimester increased from 82.5 percent to 83.2 percent.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The MCH Block Grant is intended to provide funding to states to strengthen their public health infrastructure and to address service delivery gaps for women and children that are not addressed by any other public or private program. The current formula takes into consideration the number of low-income children in a state in proportion to the number of low-income children in the nation. In addition, the program is designed to be a partnership in which the state also has a significant stake in providing for the services of mothers and children (3 of every 4 Federal dollars are matched by states.)	Title V of the Social Security Act.	20%	0.2
Total Section Score					**100%**	**100%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning (Yes,No, N/A)						
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	HRSA's Maternal and Child Health Bureau (MCHB) has developed its own 5-year strategic plan, which provides 3 goals and 27 specific objectives that focus on eliminating barriers and health disparities, assuring quality of care, and improving health infrastructure (states report on 18 nationally uniform targeted measures). MCH performance goals are also included in Healthy People 2010 and supported by HRSA. MCHB activities are also addressed in HRSA's 5-year plan. In addition, OMB and HRSA/MCHB recently developed ambitious long-term outcome goals that link to the mission of the program. Baseline data are available for all new measures.	HRSA/MCHB's newly developed long-term outcome goals are: 1) Increase maternal survival to 8 maternal deaths per 100,000 live births by 2008, 2) Reduce infant deaths to 6.5 per 1,000 live births by 2008, 3) Decrease the number of uninsured children to 8 million by 2008, and 4) Reduce neonatal deaths to 4.5 per 1,000 live births by improving the quality of prenatal care by 2008.	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	HRSA's GPRA plan includes annual goals. OMB and HRSA/MCHB recently developed discrete, quantifiable, and measurable annual performance goals that demonstrate progress toward achieving the long-term goals established.	A few of HRSA/MCHB's newly developed annual goals are: 1) Reduce illness and complication due to pregnancy to 26 per 100 deliveries, 2) Reduce the incidence of low-birth weight to 7.3 percent, 3) Increase the number of children receiving Title V services who enroll in and have Medicaid and SCHIP coverage to 7 million, and 4) Increase to 85 percent low birth weight babies who are delivered at facilities for high-risk deliveries and neonates.	14%	0.1
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	In 1997, MCHB gained States' support and commitment to reporting requirements developed in collaborative efforts with States to identify performance measures and data that would support the goals of the program. Every State sets target values for each of 18 measures for a five-year period and reports annually on actual performance. The data contained in the annual report and application submitted each July, report achievements and set targets for the upcoming fiscal year.	1) Title V Information System. 2) http://www.mchdata.net.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	No other programs in the Federal government share all of the goals and objectives of the MCH Block Grant; however, the program coordinates broadly with programs that share one or more of its goals and objectives. Primary partnerships are with State MCH and Children with Special Health Care Needs programs. MCHB has also forged partnerships with 275 organizations and programs, including national public and private organizations, state and local governments. In addition, States match $3 of every $4 Federal dollars provided, which leverages $2.3 billion from States. MCHB also has partnerships with CMS to encourage Medicaid eligible children to apply for SCHIP.		14%	0.1
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	No	Independent and quality evaluations of the MCH Block Grant or its large subparts (CISS and SPRANS) do not regularly occur, even to fill gaps in performance evaluation. The scope of the numerous evaluations that occur each year by academic researchers, state Department's of Public Health, and other institutions is insufficient to assess the Block Grant. The evaluations are of state-specific, local-level activities funded with Title V resources. As a result it is difficult to assess the impacts of the overall MCH Block Grant.	1) Virginia Resource Mothers Program, 2001 Annual Report. 2) National Center for Children, Families and Communities. 3) Texas Department of Public Health, March 2001.	14%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	HRSA's OMB budget justification and Congressional justification display the line item for the MCH Block Grant. However, when HRSA submits its budget request to the Department for review, the annual targets are adjusted according to the funding level requested and/or the final funding level provided by the Department, not based on estimates generated from a model/mechanism in place that allows for cost per unit of service/marginal dollar change projections. HRSA has made improvements in its internal control system by integrating planning and budgeting and developing annual targets associated with the program activity; however, HRSA has not yet moved to being able to make budget decisions using a more precise and detailed system of costing that is also linked to adjusting targets to achieve the established long-term and annual performance goals.	1) OMB Budget Justification submitted each Fall. 2) Congressional Justification submitted each February with the President's Budget.	14%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	Current evaluation efforts include bi-annual audits, annual reviews and 5 year State needs assessments and national surveys. HRSA is working on a customer satisfaction survey. In addition, each year input is sought from states on the planning for strategic management of the universal goals that are reported by all states.		14%	0.1
Total Section Score					**100%**	**71%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section III: Program Management (Yes,No, N/A)						
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	HRSA regularly collects data through its automated Title V Electronic Reporting Package. This information is used by internal and external experts to review each State's performance and budget data based on previous projections and future plans. Teams meet with each State to review their performance plans. States provide additional information to correct necessary data. Information is shared publicly on the MCHB's website so that States may assess their progress with other States and use this information to manage better.	http://www.mchdata.net	11%	0.1
2	*Are Federal managers and program partners (grantees, sub grantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The Federal managers of the MCH Block Grant negotiated with States to develop a national set of 18 performance measures to increase States' accountability. Some of these core measures are included in the MCHB Associate Administrator's individual performance contract. States are also encouraged to develop special State-specific measures that address their own priority needs.	http://www.mchdata.net	11%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	HRSA/MCHB has obligated its funding by quarter fairly consistently over the years. Funds are obligated nearly evenly across all four quarters. Financial status reports show minimal unobligated balances. MCHB monitors grantee expenditures to ensure compliance with legislation, regulation and policies.	1) Estimated obligations by quarter in apportionments for FYs 1999-2001. 2) Actual obligations by quarter for FYs 1999-2001. NOTE: All grantees expending above $300,000 in Federal funds provide Single Audit Act reports.	11%	0.1
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	The MCHB is in the process of implementing several IT improvements, including a web-based application for the MCH Block Grant to become effective during the FY 2003 reporting cycle. It is expected that this process will reduce the time and effort needed for States to prepare and submit their Block Grant Application and Annual Report and ensure that MCHB can post data provided within the first quarter of the new fiscal year.	1) Title V Electronic Reporting Package. 2) http://www.mchdata.com.	11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program's annual budget requests are not derived in such a way that HRSA is able to track the full annual costs associated with achieving long-term or annual goals. HRSA's current methodology is to request and track most programs' administrative and overhead costs in a Program Management line item and then allocate these resources to the program. Program staff do not have a model/mechanism in place for determining overhead on a per unit basis nor are they able to integrate program costs with the costs necessary to achieve the long-term and annual goals. Like most other agencies across government, HRSA develops its budget using the reverse methodology. HRSA identifies the funding level, then increases or decreases its annual targets according to the funding level proposed.	1) Estimated obligations by quarter in apportionments for FYs 1999-2002. 2) Actual obligations by quarter for FYs 1999-2002.	11%	0.0
6	*Does the program use strong financial management practices?*	No	HRSA financial statements are conducted by the Program Support Center. Staff reviewed financial reports within a five year time frame for which there was an internal control material weakness identified for MCH activities in 2000. The FY 2000 Annual Report includes the following statement regarding fluctuations in net cost for the year, "Maternal and Child Health costs decreased by twenty-two percent ..., over amounts reported in its fiscal 1999 financial statements. Management could not initially provide explanations for these fluctuations, which indicates a lack of complete understanding of the operating results reflected in HRSA's accrual [based] financial statements...".	FY 1997-2001 HRSA Annual Reports.	11%	0.0
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	Each year financial management deficiencies are corrected. HHS is developing a financial system to better track overall financial management across the Department.		11%	0.1
8 (B 1.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	The MCHB uses grant applications, face-to-face reviews of State plans and annual reports, bi-weekly conference calls with regional office staff, special subject matter meetings, technical assistance, and site visits by regional staff to monitor grantee activities.		11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
9 (B 2.)	*Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	Data are collected from grantees and are published each calendar year and made available to grantees and the public on the MCHB website. Hard copies of state data are also available.	1) Title V - A Snapshot of Maternal and Child Health. 2).http://www.mchdata.net/Reports_Graphs/finmenu.htm.	11%	0.1
Total Section Score					**100%**	**78%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section IV: Program Results (Yes, Large Extent, Small Extent, No)						
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Yes	The MCH Block Grant has contributed to the overall decline in the number of babies born with low birth weight and the rate of infant mortality. The Block Grant has also increased the number of uninsured children receiving access to care and has played an important part in the overall health outcomes of mothers and children. State MCH agencies have made significant progress in realizing long-term MCHB goals.	http://www.mchdata.net/Reports_Graphs/finmenu.htm.	20%	0.2

Long-Term Goal I: **Reduce Deaths**	Increase maternal survival to 8 maternal deaths per 100,000 live births.
Target:	8 maternal deaths per 100,000 live births by 2008.
Actual Progress achieved toward goal:	8.3 maternal deaths per 100,000 live births in 1999; 9.4 maternal deaths per 100,000 live births in 1980.
Long-Term Goal II: **Improve Access to Care and**	Reduce infant deaths to 6.5 per 1,000 live births by 2008.
Target:	6.5 deaths per 1,000 live births by 2008.
Actual Progress achieved toward goal:	6.9 deaths per 1,000 live births in 2000; 7.6 deaths per 1,000 live births in 1995.
Long-Term Goal III: **Reduce Health Disparities**	Decrease the number of uninsured children to 8 million by 2008.
Target:	8 million uninsured children by 2008.
Actual Progress achieved toward goal:	8.4 million uninsured children in 2000; 10 million uninsured children in 1998.
Long-Term Goal IV: **Improve Quality of Care and Treatment**	Reduce neonatal deaths to 4.5 per 1,000 live births by improving the quality of prenatal care by 2008.
Target:	4.5 neonatal deaths per 1,000 live births by 2008.
Actual Progress achieved toward goal:	4.7 neonatal deaths per 1,000 live births in 1999;4.9 neonatal deaths per 1,000 live births in 1995.

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program (including program partners) achieve its annual performance goals?*	Large Extent	The MCH Block Grant has enhanced access to care for many mothers and children. Overall, the Block Grant and State partners have been achieving their annual performance goals. However, in the case of the ambitious goal to reduce the incidence of low birth weight births, most States have not achieved their targets. Increases in number of multiple births and increased maternal age, as well as unknown factors have increased the incidence of low birth weight infants, despite increased efforts. This issue is being studied by outside entities to determine what action is needed to improve the outcome.		30%	0.2

Key Goal I:	Reduce illness and complication due to pregnancy to 26 per 100 deliveries.
Linked to L-T Goal I	
Performance Target:	Reduce by 1 illnesses/complication per 100 deliveries each year.
Actual Performance:	31.4 illnesses/complications per 100 deliveries in 1999; 31.2 illnesses/complications per 100 deliveries in 1998.
Key Goal II:	Reduce the incidence of low birth weight births to 7.3 percent.
Linked to L-T Goal II	
Performance Target:	Reduce by .06 percent each year the incidence of low birth weight births.
Actual Performance:	7.6 percent in 2000; 7.3 percent in 1995.
Key Goal III:	Increase the number of children receiving Title V services who enroll in and have Medicaid and SCHIP coverage to 7 million.
Linked to L-T Goal III	
Performance Target:	Increase the number of children by 200,000 per year.
Actual Performance:	6 million in 2000; 4 million in 1998.
Key Goal IV:	Increase to 85 percent low birth weight babies who are delivered at facilities for high-risk deliveries and neonates.
Linked to L-T Goal IV	
Performance Target:	Increase percent of babies by 2.5 percent each year that are born with low-birth weight at facilities for high-risk deliveries.
Actual Performance:	72.5 percent in 1999; 70.6 percent in 1998.

3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Yes	The MCH Block Grant demonstrates cost effectiveness. The MCH Block Grant's contribution to these activities has remained relatively flat, yet goals are being met and health outcomes are improving.		25%	0.3
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	NA			0%	

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Small Extent	Many of the 59 States and Territories that receive MCH Block Grant funds have had academic researchers, state Department's of Public Health, and other institutions evaluate the performance of specific activities funded under the Block Grant. These limited in scope evaluations have shown that local level activities funded by the MCH Block Grant achieve results. However, because independent and quality evaluations of the MCH Block Grant as a whole or even in large subparts (CISS or SPRANS) are not conducted, full credit can not be provided.	A 2001 Annual Report by Virginia Resource Mothers Program addressed the rate of low-birth weight babies for those teens receiving services from a program funded with Title V resources compared to nonparticipating teens. Those teens that are not participating in interventions funded with Title V resources have had higher rates of birthing children with low birth rates.	25%	0.1
Total Section Score					**100%**	**73%**

Program Assessment Rating Tool (PART)

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	
80%	100%	71%	67%	Moderately Effective

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The purpose of the Medicare program is to finance health insurance for eligible individuals through a combination of social insurance and general federal revenues and by doing so, prevent beneficiaries from becoming impoverished.

Evidence: In 1965, about half of the elderly had health insurance for hospital services. Medicare's enactment extended health insurance coverage to nearly all of the nation's elderly. (see Title XVIII of the Social Security Act - www.ssa.gov/OP_Home/ssact/title18/1800.htm) Over the 38 years of Medicare's existence, poverty rates among the elderly have fallen from about 20 percent to about nine percent.

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: Prior to Medicare, many elderly and disabled individuals lacked access to health care, and there was a widely perceived market failure in health insurance for this population. The elderly have health care costs four times that of the under 65 population and the disabled also have high health care expenditures; Medicare provides a significant public subsidy to finance these health care costs. In the absence of the Medicare program, many elderly and disabled generally would not have sufficient resources to pay for their health care.

Evidence: Medicare's enactment led to: increased use of health care services by the elderly, especially minorities; lower poverty rates; longer life expectancy; and individuals with ESRD gaining access to life saving services (see Health Care Financing Review 35th Anniversary Issue Fall 2000: www.cms.hhs.gov/review/00fall/00fall.asp). See charts 1.21, 3.8, 3.12, 3.13, and 3.15 at www.cms.hhs.gov/charts/healthcaresystem. See also table 4.8 at www.cms.hhs.gov/mcbs/mcbssrc/ 1998/98cbc3d.pdf.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: Medicare is a national program to ensure that program beneficiaries receive medically necessary acute health care services. In most cases, Medicare is the primary payer and makes a unique contribution. Other sources of insurance, such as private sector supplemental insurance, employer retiree benefits and Medicaid, wrap around Medicare.

Evidence: Medicare is the primary source of health insurance coverage for most beneficiaries. Many beneficiaries also have a source of supplemental insurance to cover non-covered services as well as co-pays and deductibles. For information on supplemental coverage see: http://www.medicare.gov/mgcompare/home.asp and http://www.medicare.gov/mphCompare/home.asp. See evidence for questions 1 and 2 above.

Program Assessment Rating Tool (PART)

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	
80%	100%	71%	67%	Moderately Effective

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: NO Question Weight: 20%

Explanation: Although CMS operates the Medicare program effectively within the benefits and payment systems established by statute, the program's benefits are no longer state of the art. Medicare's benefits and payments were modeled on the typical private-sector health insurance of 1965. Although a number of changes have been made to Medicare to reflect the changing needs of program beneficiaries and changes in health care delivery (e.g., coverage of hospice care, unlimited number of home health visits, and preventive benefits), the program again needs to be updated. For example, Medicare does not cover most outpatient prescription drugs. Medicare, however, is constrained to operate within existing statutory authority, meaning that legislation is necessary for broad changes. Recently enacted Medicare modernization legislation will give beneficiaries the option of a drug benefit beginning in 2006; it also makes other changes to the program. Future PART assessments of Medicare will likely revisit this question in light of the new law.

Evidence: Several features of the Medicare program reflect its outdated statutory design. For example, unlike most private health insurance, Medicare does not protect beneficiaries against high out-of-pocket costs - i.e., it does not provide catastrophic protection. Medicare sets reimbursement through administratively determined prices that do not always keep pace with advances in medical practices or changes in the health care market. Medicare cannot use modern acquisition practices, including those used commonly by other government agencies, to procure claims processing services. Updating the statutory design will allow Medicare to better serve beneficiaries.

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: Medicare is an entitlement program for elderly and disabled individuals, as well as individuals with ESRD. In order to receive benefits under the program, individuals must meet statutorily defined eligibility criteria. Medicare funding is spent for program purposes, not diverted to other purposes.

Evidence: The Social Security Act defines the eligibility criteria for Medicare. (See title XVIII of the Social Security Act, Sec. 1811 and Sec. 1831, at www.ssa.gov/OP_Home/ssact/title18/1811.htm) Virtually all eligible beneficiaries participate in Medicare. The Medicare error rate, less than 6 percent, is at an historic low and indicates that program funding is not being misspent or misdirected.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 17%

Explanation: Performance measures have been established that analyze both health-care/clinical and management/efficiency aspects of the program. These measures focus reflect the purpose of the program.

Evidence: Some evidence comes from CMS sources, such as the FY 2004 Annual Performance Plan and Report and the Medicare Current Beneficiary Survey (MCBS). Other evidence comes from external sources, such as Healthy People 2010 and reports issued by the Medicare Payment Advisory Committee, using MCBS and other program survey data. Goals and targets are listed in the Measures tab.

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation: Targets and timeframes are ambitious.

Evidence: Some evidence comes from CMS sources, such as the FY 2004 Annual Performance Plan and Report and the MCBS. Other evidence comes from external sources, such as Healthy People 2010 and reports issued by the Medicare Payment Advisory Committee, using MCBS and other program survey data. Goals and targets are listed in the Measures tab and set high standards for the program.

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	
80%	100%	71%	67%	Moderately Effective

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 14%

Explanation: Medicare has annual performance measures that will track progress on the program's long-term goals. These measure track financial management, access to quality health care, beneficiary satisfaction, and administrative efficiency.

Evidence: Refer to "Measures" tab for listing of pertinent annual goals.

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: Medicare has targets and baselines for most of its goals. Meeting these goals will improve the operation of the program and yield meaningful improvements for beneficiaries. For some areas Medicare needs to establish performance measures, such as cost-efficiency of claims processing and the quality of care for chronic diseases.

Evidence: Refer to "Measures" tab for listing of measures, baselines and targets.

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 15%

Explanation: CMS establishes annual performance standards for fiscal intermediaries and carriers that are consistent with applicable GPRA goals and strategic program goals. Key performance indicators are used to measure the success of CMS business partners in achieving program goals. Partners commit to these performance standards through the annual contract renewal process. The leadership of the Medicare contractor community, through the Contractor Consultation Group, participates in monthly discussions on program objectives with CMS leadership, and CMS holds bi-annual executive meetings with contractor leadership to discuss these goals. Medicare would benefit, however, from additional flexibility to select and reward contractors for high performance. This increased flexibility would provide better incentives for contractors to support the performance goals of Medicare. In addition, Medicare managed care plans are required to conduct annual quality improvement projects on a variety of health issues to improve the quality of health care services.

Evidence: CMS conducts performance reviews of its Fee-For-Service (FFS) contractors in areas of high importance. The most critical standards are measured for all contractors and other functions are reviewed based on risk levels, contractor historical performance, and exposure. SAS-70 reviews of internal controls are also conducted in high risk areas. Deficiencies are carefully monitored and contractors are required to submit Corrective Actions Plans (CAPs) if needed. Other CMS partners, such as 1-800-MEDICARE and managed care contractors, are evaluated in terms of stakeholder approval via customer satisfactions surveys, particularly the Consumer Assessment of Health Plans Survey (CAHPS). CMS does not yet have quality data from Medicare managed care plans. CMS based the 6th Round quality improvement organization (QIO) contractor performance evaluation on QIOs ability to improve Statewide performance on various quality measures. Articles published in JAMA (October 2001 and January 2003) provide information on the baseline data collection for identified quality measures for the QIO Program.

Program Assessment Rating Tool (PART)

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	
80%	100%	71%	67%	Moderately Effective

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?**

Answer: YES Question Weight: 14%

Explanation: Medicare is perhaps one of the most-studied federal programs in existence. In addition to work supported by CMS and the Department of Health and Human Services, many independent analysts and organizations study the Medicare program each year.

Evidence: Among the numerous sources of Medicare analysis are the Medicare Payment Advisory Commission (www.medpac.gov), the National Academy of Social Insurance (www.nasi.org), the Kaiser Family Foundation (www.kff.org), the American Enterprise Institute (www.aei.org), the Heritage Foundation (www.heritage.org), the Center on Budget and Policy Priorities (www.cbpp.org), the Commonwealth Fund (www.cmwf.org), the Center for the Study of Health System Change (www.hschange.org), and Mathematica Policy Research (www.mathematica-mpr.org). Many of these organizations reports spur programmatic changes in Medicare. For example, MedPAC recommendations are often the basis for legislative and regulatory changes, and Mathematica evaluations help refine Medicare demonstration projects.

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?**

Answer: NA Question Weight: 0%

Explanation: The answer to this question is an NA because Medicare is a mandatory program and its budgetary resources are not driven by performance goals.

Evidence:

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?**

Answer: YES Question Weight: 15%

Explanation: In Spring 2001, the CMS Administrator targeted three areas for improvement: agency responsiveness, health care quality, and consumer information, as these are directly linked to CMS's ability to set program goals and establish measures. CMS is reaching out to partners to improve agency responsiveness, working with providers to publish state of the art information on health care quality, and working to provide Medicare beneficiaries with additional information to support informed choice of health plans and providers. Going forward, CMS should strengthen its capabilities in forecasting health care trends and developing long-term policy analysis and options for the Medicare program.

Evidence: Responsiveness: Open door initiatives are available at: www.cms.hhs.gov/opendoor/; since October 2001, more than 15,450 people have participated in these forums. The quarterly provider update gives providers regular and predictable information on program changes (see www.cms.hhs.gov/providerupdate). Quality: Home health agency and nursing home quality indicators are public and efforts to add hospitals and physicians are underway. Quality information on the web includes: www.cms.hhs.gov/quality/hhqi/; www.cms.hhs.gov/quality/hospital/; www.cms.hhs.gov/providers/nursinghomes/nhi/; www.cms.hhs.gov/quality/doq/. Consumer Information: CMS has developed an enhanced Medicare & You campaign, including a web-based personal plan finder.

Program Assessment Rating Tool (PART)

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	
80%	100%	71%	67%	Moderately Effective

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 14%

Explanation: CMS regularly collects data to measure beneficiary satisfaction. Information from the MCBS, which combines survey data with data from CMS's administrative systems, gives a detailed portrait of health care use, expenditures, and financing by subpopulations of beneficiaries. This information is used to implement strategies to meet the needs and demands of its beneficiaries. CMS constantly monitors FI & carrier contractor production, as well as quality and cost data (includes claims processed, appeals workload, and beneficiary/provider inquiries). Information from FIs and carriers is collected no less than monthly and compared to other time periods to determine trends early so program resources can be allocated appropriately. In addition, CMS reviews managed care plan marketing materials, audits their operations, reviews financial reports and monitors HEDIS, HoS, CAHPS, and disenrollment survey data.

Evidence: FFS contractors are required to regularly submit production and cost information to CMS for review. Reports are complemented by on-site reviews by headquarters and field staff. Based on information from these sources, CMS issues formal directives to address emerging issues, concerns of the agency, or changes in agency priorities. Through the Comprehensive Error Rate Testing (CERT) program, CMS gathers data to support its efforts to counteract fraud, waste, and abuse. Clinical Data Abstraction Centers provide data (acquired primarily through abstraction of medical records) to both QIOs and CMS to assist in the assessing individual QIO and overall program performance. In addition, data on national and state-specific clinical quality of care measures is also obtained from various sources. For example, data on low immunization rates among the Medicare population spurred administrative changes to facilitate vaccination rates among institutionalized beneficiaries.

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: NO Question Weight: 14%

Explanation: Statutory requirements make it hard to hold key partners accountable. Most reimbursement is based on estimates of procedure cost; high-quality providers receive the same reimbursement as low-quality providers. On the administrative side, outdated statutory requirements prevent use of modern procurement practices for hiring contractors to process claims. These obstacles impede the ability of Medicare to hold key program partners accountable for cost, schedule, and performance. Despite these challenges, Medicare has made significant progress in some areas. Several demonstration projects are experimenting with paying providers bonuses for meeting quality guidelines. Medicare has also made important advances with administrative partners, competing the Program Safety Contractors, and developing performance-based metrics for Quality Improvement Organizations (QIO) contracts. It will be difficult for Medicare to hold others accountable for program funds until legislative changes permit compensating efficient and high-quality providers and contractors.

Evidence: Medicare has launched demonstrations that reimburse health care providers for quality, but more than 99% of reimbursement is based on cost or a prospective payment system that does not reward high-quality care. For partners in the administration of Medicare, some important steps have occurred but more work remains. CMS has created performance agreements for senior staff and is expanding this practice to other staff. However, both GAO and HHS believe that the outdated contracting requirements do not allow sufficient incentives for contractors to provide high-quality service. Expanding the appropriate use of performance-based contracts will require a long-term commitment by HHS and other stakeholders in the Medicare program.

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	Moderately Effective
80%	100%	71%	67%	

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 14%

Explanation: Through the Financial Management Investment Board (FMIB), CMS has developed effective oversight of its Program Management funding. In FY 2002, lapse rates were: <0.2 of 1% for Program Management and <0.6 of 1% for HCFAC. In the last complete 3-year cycle of the PROs (now QIOs), <0.03 of 1% remained unobligated. Finally, the clean opinion on the agency financial statements and a lack of GAO/OIG findings in this area are evidence that the funds were spent as the Congress intended. The Medicare error rate, a related issue, is cited in Section IV.3.

Evidence: CMS Financial Report for FY 2002; CMS FY 2002 Annual Performance Report, as well as the Annual Performance Plans for FY 2003 and FY 2004. Data related to computing the lapse rates are available on the agency execution documents, e.g., forms SF-133, and the OMB report of the FACTS II single general ledger account balances.

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: YES Question Weight: 14%

Explanation: Medicare has key indicators of efficiency for administrative and benefits expenditures, but still lacks measures for some key areas. For administrative expenditures, CMS tracks cost per claim, and has achieved some efficiencies through electronic claims processing. CMS plans to process the data gathered from managed care organizations (MCOs) through a performance assessment mechanism, in conjunction with other information, to determine the necessity and scope of audits. This will allow CMS to better utilize its limited resources. In addition, CMS awards QIO contracts for a 3-year term; during each renewal period, contractors failing to pass the performance evaluation are subject to full and open competition. However, CMS does not have a metric for measuring the effectiveness/efficiency of its allocation of federal staff to different Medicare program operations.

Evidence: Several management practices push administrative partners to operate efficiently. CMS measures the cost-per-claim and is starting a pilot of performance based contacting with three of its current contractors. Contractors strive to meet CMS performance objectives to secure contract renewal. For competitive sourcing efficiencies, CMS is in the process of completing cost comparisons as required by OMB circular A-76. Other initiatives (e.g., the Medicare managed care system redesign, and activities in the Revitalization proposal) are geared towards modernizing systems and infrastructure to take advantage of the efficiencies offered by modern technology and increase the timeliness and reduce the administrative burden of Medicare's accounting. Program safety contractors are held to performance-based contracts that provide incentives for effectiveness. In some areas, however, program partners are not held accountable for consistent business practices -- for example, the regional variation in claims processing decisions at different DME regional contractors.

Program Assessment Rating Tool (PART)

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	
80%	100%	71%	67%	Moderately Effective

3.5 **Does the program collaborate and coordinate effectively with related programs?** Answer: YES Question Weight: 14%

Explanation: CMS collaborates with a number of government agencies that also fund or provide services to Medicare beneficiaries. CMS also works closely with other federal and state agencies that provide important support functions or collaborative efforts that assist CMS in serving Medicare beneficiaries.

Evidence: CMS works with VA and DOD on improving quality and demonstrations. SSA and CMS work together in numerous areas, including initial enrollment of Medicare beneficiaries, back-to-work efforts for disabled beneficiaries, and Medicare appeals. CMS works with FDA, VA and NIH to better coordinate the review of new technologies. CMS cooperates with NIH and AHRQ on research and with IHS on Medicare payment issues. CMS participates in the National Quality Forum with many others. CMS coordinates with state agencies for Medicaid dual eligibles and survey and certification; and state insurance commissioners on Medigap. CMS collaborates with CDC and NIH on quality goals, including flu and pneumoccocal vaccinations, mammography, and surgical site infections.

3.6 **Does the program use strong financial management practices?** Answer: NO Question Weight: 14%

Explanation: HHS received a clean audit for 2002, but problems with Medicare's accounting are a major factor in a material weakness cited by auditors. The antiquated accounting system Medicare currently uses cannot provide accurate program data in a timely manner. The inability to produce timely financial data makes it difficult to analyze expenditures and identify emerging trends in program spending. As a result, there are significant lags in data available to analysts, and the inability to quickly spot changes in expenditures increases the program's vulnerability to fraud, waste, and abuse. The deployment of a new accounting system will address some of these problems.

Evidence: The HHS FY 2002 Auditor's Report details material and other weaknesses in Medicare's accounting. The weaknesses include a lack of a general ledger for claims processing activities (which process over $238 billion in claims), and weak accounting practices at Medicare contractors. A recent example that demonstrates the program impact of inadequate financial information is the discovery that some hospitals were exploiting Medicare hospital outlier policy to gain significant, unwarranted increases in reimbursement.

3.7 **Has the program taken meaningful steps to address its management deficiencies?** Answer: YES Question Weight: 14%

Explanation: Under the Federal Managers Financial Integrity Act requirement, CMS continually evaluates program operations to ensure that there are management controls to protect from fraud, waste, and abuse. Efforts to reduce the error rate have resulted in a new focus on provider education to ensure sufficient documentation of claims. In addition, CMS is planning many IT improvements designed to achieve efficiencies and cost effectiveness.

Evidence: As reported in the FY 2002 financial report, CMS assesses its management controls through reviews, the financial audit, OIG audits, management self-certifications, and other review mechanisms, such as Statement of Auditing Standards (SAS -70) internal control reviews. CMS also requires corrective action plans for material issues identified. A new accounting system (HIGLAS), the Medicare managed care system redesign, and the activities in the Revitalization proposal are all geared towards modernizing systems and infrastructure to take advantage of the efficiencies offered by modern technology and permit addressing our current business needs, which are dramatically different from those at the time of Medicare's inception.

Program Assessment Rating Tool (PART)

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	
80%	100%	71%	67%	Moderately Effective

4.1 Has the program demonstrated adequate progress in achieving its long-term performance goals? Answer: LARGE EXTENT Question Weight: 25%

Explanation: The program demonstrates progress in achieving some of its long term goals. See data in measures tab.

Evidence: The MCBS and CAHPS demonstrate high levels of beneficiary satisfaction. The annual performance plan includes performance goals related to access and satisfaction (See p. VI-13 of FY2004 APP/APR, as well as the APP for goals related to Medicare payment systems at p. VI-155). Quality of care performance goals include increasing the percentage of beneficiaries who receive an influenza vaccination (p. VI-31, pp. VI-22-VI-41). Increasing beneficiary understanding of the Medicare program and providing beneficiaries with information to help them in their health care choices is accomplished through the Medicare and You Handbook and major media and outreach campaigns. CMS has targets for measuring improvement in beneficiary understanding of the basic features of the Medicare program (see APP p. VI-142).

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: LARGE EXTENT Question Weight: 25%

Explanation: The Medicare program has reported positive results on its annual performance goals, see data in "Measures" tab, but still has areas in which improvements are needed.

Evidence: The CMS FY 2004 Annual Performance Plan and Report.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: SMALL EXTENT Question Weight: 25%

Explanation: Medicare has made strides to achieve its goals, but work remains in some key areas. On the benefits side numerous observers (including the GAO and the IG) and Medicare's current leadership acknowledge that payment for Part B-covered drugs is inefficient and inappropriate when compared to the acquisition cost of these drugs and comparable payment in the private sector. Similar concerns exist with respect to Durable Medical Equipment (DME). On the administrative side, the erroneous payment rate has been reduced from 1996 levels, but Medicare has not achieved its annual target since 2000. On cost per claim, electronic processing yielded major efficiencies in the 1990s, but costs for some claims have been increasing in recent years.

Evidence: For information on Part B drugs, see, for example, GAO-02-833T and GAO-02-531T. Payment error rates were computed by the OIG at 6.3% for FY 2002 compared to 14% in FY 1996; the target rate, however, is 5%. Electronic claims now make up 98% and 85% of Part A and Part B total claims, respectively. Unit costs per claim have been cut nearly in half since FY 1989, but are creeping upward or remaining flat. For CFO audit results, see CFO Report 2002, APP p. VI-132. Other evidence: CMS 3/18 letter requesting suggestions on efficient study topics; Qualis (WA QIO) contract to sponsor collaboratives (learning/information sharing sessions); MedQIC database.

Program ID: 10001060

Program Assessment Rating Tool (PART)

Program: Medicare
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Direct Federal

Section Scores				Overall Rating
1	2	3	4	
80%	100%	71%	67%	Moderately Effective

4.4 **Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?**

Answer: NA Question Weight: 0%

Explanation: Medicare is unique in its scope and mission - it is the only community-rated social insurance program in the country. The beneficiary population is heterogeneous: diverse in income, race, health status, and geographic location, among other factors. Other federal health programs (e.g., the Department of Defense) serve far smaller and more targeted patient populations. Moreover, unlike private health insurance, Medicare premiums are not influenced by age or prior health status.

Evidence:

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?**

Answer: YES Question Weight: 25%

Explanation: CMS routinely contracts out independent evaluations of key program features and uses the results of the evaluations to make improvements to the program. Recent examples of important evaluations include the Medicare & You education program and M+C disenrollment study. In addition, the National Academy of Social Insurance has a number of recent studies on facets of the Medicare program (fee-for-service, M+C, chronic care, and CMS as an agency) which find that the program is effective in providing program beneficiaries with access to affordable health care services. Provider performance on identified quality measures improved over the time period 1999-2002, thereby contributing to achieving program goals. Although this evaluation was not conducted by an entity independent of CMS, the information obtained was used to support program improvements and to evaluate the effectiveness of the QIO Program.

Evidence: MedPAC reports that the Medicare program is generally successful in ensuring that beneficiaries have access to high quality medical care, the primary goal at enactment. Even while celebrating the success of Medicare, the NASI reports (and the studies of other prestigious panels) make a number of recommendations for improvements to Medicare, see www.nasi.org/publications2763/publications_list.htm?cat=Reports; see Health Care Financing Review 35th Anniversary Issue Fall 2000: cms.hhs.gov/review/00fall/00fall.asp. A list of current CMS sponsored evaluations is in the Active Projects Report at cms.hhs.gov/researchers/projects/APR/ default.asp#theme1. CMS reviewed 311 reports from the GAO and OIG last year. After review, CMS takes needed corrective actions. CMS studies external analyses of Medicare to develop program improvements. Articles published in JAMA (October 2000 and January 2003) provide information on the baseline data collection for identified quality measures for the QIO Program and the remeasurement of those quality measures.

PART Performance Measurements

Program: Medicare

Agency: Department of Health and Human Services

Bureau: Centers for Medicare & Medicaid Services

Measure: Percent of beneficiaries receiving antibiotic administration to reduce surgical site infection

Additional Information: Increase over baseline

Year	Target	Actual
2001		57.6%
2003	60.5%	
2004	66.5%	
2005	72.5%	

Measure Term: Annual

Measure: Audit opinion on CMS financial statement.

Additional Information: Maintain a "clean" unqualified opinion on CMS's financial statements.

Year	Target	Actual
1998		Qualified opinion
1999	Unqualified opinion	Met
2000	Unqualified opinion	Met
2001	Unqualified opinion	Met
2002	Unqualified opinion	Met
2003	Unqualified opinion	
2004	Unqualified opinion	
2005	Unqualified opinion	
2007	Unqualified opinion	
2006	Unqualified opinion	

Measure Term: Long-term

PART Performance Measurements

Program: Medicare

Agency: Department of Health and Human Services

Bureau: Centers for Medicare & Medicaid Services

Measure: Percent of Medicare beneficiaries receiving influenza vaccination.

Additional Information: Increase percentages over baseline

Year	Target	Actual	**Measure Term:**	Annual
1994		59%		
2001	72%	67.4%		
2002	72%	69%		
2003	72.5%			
2004	72.5%			

Measure: (1) Percentage of Medicare beneficiaries who are aware of the 1-800-MEDICARE toll free number, and (2) number of questions about Medicare out of 6 answered correctly.

Additional Information: Increase percentages and numbers in (1) and (2), respectively

Year	Target	Actual	**Measure Term:**	Annual
2000		53%;2.75		
2001	Develop survey	Goal met		
2002	Develop targets	Goal met		
2003	Collect/monitor data			
2004	65%;3.50			

Measure: Erroneous payments made under the Medicare program

Additional Information: Reduce percentage from baseline

Year	Target	Actual	**Measure Term:**	Annual	(Efficiency Measure)
1997		11%			

PART Performance Measurements

Program: Medicare

Agency: Department of Health and Human Services

Bureau: Centers for Medicare & Medicaid Services

Measure: Erroneous payments made under the Medicare program

Additional Information: Reduce percentage from baseline

Year	Target	Actual
2002	5%	6.3%
2003	5%	5.8%
2004	4.8%	
2005	4.6%	
2006	4.4%	

Measure Term: Annual (Efficiency Measure)

Measure: Percent of women who receive a biennial mammogram.

Additional Information: Increase percentages over baseline

Year	Target	Actual
2001		51%
2002		51.6%
2003	51.5%	
2004	52%	
2005	52.5%	

Measure Term: Annual

Measure: Percent of diabetic beneficiaries who receive diabetic eye exams.

Additional Information: Increase the percentage over baseline

Year	Target	Actual
2001	68.3%	68.1%
2002	68.6%	69.2%

Measure Term: Long-term

PART Performance Measurements

Program: Medicare

Agency: Department of Health and Human Services

Bureau: Centers for Medicare & Medicaid Services

Measure: Percent of diabetic beneficiaries who receive diabetic eye exams.

Additional Information: Increase the percentage over baseline

Year	Target	Actual	**Measure Term:** Long-term
2003	68.9%	69.6%	
2004	69.2%		
2005	70.1%		

Measure: Percent of Medicare contractors who have a 5% or better error rate

Additional Information: Increase from baseline

Year	Target	Actual	**Measure Term:** Annual
2005	25%		
2006	50%		
2007	75%		

Measure: Percent of beneficiaries in (1) FFS and (2) managed care who report access to care

Additional Information: Increase percentage over baseline

Year	Target	Actual	**Measure Term:** Long-term
2001		92.8,82.8	
2002	Collect & share data		
2003	Collect & share data		
2004	95%, 85%		
2005	Hold FY 2004 targets		

OMB Program Assessment Rating Tool (PART)

Block/Formula Grants

Name of Program: Medicare Integrity Program (HCFAC)

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The Medicare Integrity Program (MIP) was created as part of the Health Care Fraud and Abuse Control (HCFAC) program. The purpose of the MIP program is to ensure that Medicare outlays are made to the appropriate provider on behalf of eligible beneficiaries for covered services. Specifically, the program: • Identifies, eliminates, and prevents Medicare fraud and abuse; • Decreases the submission of abusive and fraudulent Medicare claims; • Takes appropriate administrative action as necessary in accordance with Medicare laws and regulations, etc., to ensure that appropriate and accurate payments for Medicare services are made, which are consistent with Medicare coding and coverage policy.	Section 1893 of the Social Security Act authorized the MIP program for the expressed purpose of protecting trust fund outlays form being made to inappropriate providers, ineligible beneficiaries, or non-covered services. http://www.ssa.gov/OP_Home/ssact/title18/1893.htm PSC statement of work at www.hcfa.gov/MEDICARE/MIP/INDEX.htm	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	MIP was expressly created to address the Medicare Fee-for-Service improper payment rate. At the time MIP was created in 1996, the rate was estimated at 14 percent, or $23.2 billion, and was due to erroneous billing, waste, fraud and/or abuse. The FY 2001 error rate is 6.3 percent, or $12 billion, which indicates that while much progress has been made, the problem still exists.	The Office of the Inspector General (OIG) has measured the Medicare Error Rate since FY 1996. The most recent report is for FY 2001 and is available at: http://oig.hhs.gov/oas/reports/cms/a0102002.pdf	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The MIP program was created as part of comprehensive legislation to combat health care fraud and abuse through the HCFAC program. MIP is the largest component of HCFAC, with approximately 70 percent of the budget. It has a multi-faceted approach to combating fraud and abuse, including provider and supplier audits, medical reviews, cost report audits, beneficiary surveys, and provider education. CMS exercises the flexibility through MIP to contract with both Medicare claims processors and distinct fraud and abuse contractors to identify and root out improper payments. Through HCFAC, the MIP program also coordinates with the HHS OIG, the FBI, and other fraud and abuse programs to ensure that all aspects of safeguarding payments are addressed -- including preventing, identifying and/or resolving errors, fraud, waste and abuse.	The Health Insurance Portability and Accountability Act (P.L. 104-191) created the HCFAC program to combat health care fraud, waste and abuse. It includes four major components (figures are for FY 2004): (1) MIP ($710-720 million) focuses on ensuring payments are made correctly; (2) OIG ($150-160 million) focuses on investigations, inspections, audits, prosecutions; (3) FBI ($114 million) similar to OIG; and, (4) Other ($81-91 million) determined each year by the HHS Secretary and Attorney General.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	Before HCFAC was created in 1996, there was no other program dedicated exclusively to reducing Medicare fraud, waste, and abuse. HCFAC legislation created a coordinated approach to fighting health care fraud, and specified unique and/or complementary activities for the agencies involved. The MIP statute outlines specific tasks for Medicare contractors and program safeguard contractors (PSCs) that emphasize prepayment reviews. (The tasks outlined for the OIG and the FBI emphasize post-payment reviews)	The HCFAC statute outlines the following activities for the MIP program (SSA Sec 1893(b)): (1) Medical, utilization, fraud and other reviews of providers (2) Cost report audits (3) Payment determinations and recoveries (4) Provider and beneficiary education (5) DME prior authorization schedule. The OIG and FBI activities include: (SSA Section 1817(k)(3)(C) (1) Prosecuting health care matters (2) Investigations (3) Financial and performance audits (4) Inspections and other evaluations (5) Provider and consumer education	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	MIP is designed to reduce improper payments by entering into contracts with the entities most qualified to accomplish the task: (1) the FIs and carriers that pay claims and are 'on the front line,' and (2) program safeguard contractors (PSCs) that specialize in the detection of fraud and abuse. Following its success in reducing some of the most obvious and egregious improper payments, the program is making changes to more precisely identify and reduce the remaining fraud, waste, and abuse. The Comprehensive Error Rate Testing (CERT) program, which will calculate sub-national error rates, is an example of this. HCFAC activities are funded through direct spending authority, with funding fixed in statute. This is one element of the program's design that is not optimal because it does not allow for an annual review of funding for health care anti-fraud activities. The agencies contend that having dedicated, mandatory HCFAC resources is an essential component of the program's design. However, there is no evidence to suggest that HCFAC could not be equally successful if these activities were discretionary. Moreover, the inherent annual review and evaluation of the discretionary process could improve a program whose success, or struggles, has no impact on its budget currently.	MIP's ability to leverage these private sector entities through its contracting authority has proved effective. There is no evidence to suggest an alternative program mechanism would be more effective. However, the passage of contractor reform which would allow CMS to competitively bid contracts for FIs and carriers would enhance MIP's effectiveness.	20%	0.2
Total Section Score					**100%**	**100%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning		**(Yes,No, N/A)**				
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	The program has three goals that focus on the core program purpose - to pay claims to the appropriate provider on behalf of eligible beneficiaries for covered services. The first goal -- reducing the national Medicare fee-for-service improper payment rate -- aligns with the President's Management Agenda to improve financial performance. The second goal supports the first goal by breaking down the national improper payment rate into contractor-specific error rates. In FY 2003, for the first time, CMS will be able to identify and manage error rates at this more detailed contractor level. The third goal also supports the first goal and focuses on ensuring that provider's are submitting appropriate claims for payment.	The first goal is to reduce the national Medicare error rate to 4 percent by FY 2008 from the FY 2001 current rate of 6.3 percent. This represents a 37 percent decrease in the current error rate. This is a sufficiently aggressive goal when considered in context: it follows on the heels of a 50 percent reduction in the Medicare error rate to 6.8 percent in FY 2000. While future reductions are attainable, it is reasonable to assume that may require more effort to achieve. The second goal is to reduce contractor specific error rates to at or below the national error rate by FY 2008. The third goal is to improve the provider compliance rate by 20% per year in FYs 2005-2008 (this is a developmental goal because there is currently no baseline).	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	The program has adopted annual goals that divide the long-term goals into intermediate annual targets. For the second and third goals, which are new to MIP, the baselines will be set in FY 2004 following the implementation of the Comprehensive Error Rate Testing (CERT) program.	The first annual goal is to reduce the national Medicare error rate to 5 percent in FY 2003 and 4.8 percent in FY 2004. The second annual goal is to set a baseline for the contractor error rate in FY 2004. The third annual goal is to set a baseline for the provider compliance rate by FY 2004.	14%	0.1
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	No	The MIP program has two main partners (1) the fiscal intermediaries and contractors that process Medicare claims and also perform fraud and abuse prevention functions and (2) PSCs that contract with CMS to perform fraud and abuse prevention activities. Currently, FIs and carriers do not explicitly commit to the national or contractor specific error rates. However, CMS's CERT program will provide them with contractor specific error rates. CMS will require contractors to commit to reducing their error rates, as reflected in their second long-term goal. Additionally, as discussed in question #7, CMS is running a "Performance-based Outcomes Pilot" which will require contractors to commit to contractor-specific error rates to receive an award fee." Complete for PSCs	CMS's performance requirements for FIs and carriers are outlined in the Budget and Performance Requirements (BPRs). The BPRs require contractors to develop strategies for fighting fraud and abuse that focus on reducing the error rate. However, contractors are not required to commit to error rate goals or similar goals that support reducing the error rate. Additionally, since contractors are paid on a cost basis by statute, their are no financial incentives or penalties if they were to be held to specific goals that support CMS strategic goal of reducing the error rate. (See question #7 for actions CMS is taking to address this situation). PSCs	14%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	MIP coordinates closely with a number of related programs that share similar goals and objectives. HCFAC was established in large part to facilitate coordination of fraud and abuse activities among different health care industry participants. Via HCFAC, MIP coordinates with the OIG and the FBI. It also coordinates with local law enforcement entities that are responsible for pursuing fraud cases. Additionally, MIP coordinates with CMS program management on initiatives to improve provider education and, therefore, compliance. MIP also coordinates with other programs, such as Medicaid, to share best practices.	CMS coordinates with the OIG, FBI and other law enforcement personnel primarily through their contractors and PSCs. CMS contractor BPRs and PSC statements of work require contractors to establish processes along many dimensions, such as timeliness of responding to beneficiary referrals and law enforcement requests. Additionally, PSCs will soon be eligible for award fees based on performance against key process measures such as those listed above.	14%	0.1
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	The MIP program is evaluated through both regular, scheduled independent studies and as needed reviews. The OIG has calculated the Medicare error rate since 1996 (although this activity will be done by a PSC contractor in the future, it will still be conducted independent of CMS).The GAO conducts regularly scheduled audits on HCFAC to determine whether funds were expended in keeping with the stated purpose of HCFAC and to ensure that, as appropriate, funds were returned to the trust fund each year. Additionally, the GAO has released a number of reports on CMS's MIP activities. CMS also undertakes a substantive test of its claims payment system in order to determine compliance with Medicare laws, regulations and guidance.	The OIG releases a report every year on the Medicare error rate. The most recent report is for FY 2001 and is available at: http://oig.hhs.gov/oas/reports/cms/a0102002.pdf) The GAO's most recent report on HCFAC, GAO-02-731, reports favorably on the disposition of funds. Additionally, the GAO has reported on CMS's management of its contractors, CMS's use of PSCs, and other aspects of CMS fraud and abuse activities.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	Total funding for MIP activities is set in statute. In the aggregate, there is no alignment between budget, policy and legislative changes and program performance. Below the line, there are multiple budget layers to consider with regard to MIP: (1) MIP budget for FIs and Carriers. Funds are used by FIs and carriers to conduct medical review, MSP and benefit integrity activities. The large majority of the MIP budget (>90 percent) goes to FIs and carriers and is primarily allocated between these contractors based on activity level rather than performance. (See question #7 for CMS actions on tying contractor budgets and performance) (2) MIP budget for program safeguard contractors (< 10 percent). This portion of MIP funds is more closely tied to performance than other portions. CMS awards these contracts for specific fraud and abuse activities and has established an award fee that PSC contractors can earn based on their performance against certain criteria. (3) Program managment funds that contractors receive for processing Medicare claims. As required by statute, these funds curre	(1) The HCFAC statute provides between $710-$720 million for MIP activities for fiscal years after 2002. (2) Contractors and FIs MIP budgets are developed through negotiations between CMS and contractors based primarily on activity levels. For example, contractors may receive funds based on the percent of claims subject to a medical review. (3) The PSCs are eligible for an award fee based on their performance against four predominantly process measures - customer satisfaction, timeliness of responses to law enforcement, beneficiary complaint response time, and acceptance of fraud and abuse cases by law enforcement. (4) Currently, contractors are paid for claims processing activities based on the number of claims processed, rather than being paid on outcomes such as their error rates.	14%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	CMS has a number of programs in focused on further strengthening strategic planning. The CERT program will allow CMS to measure the improper payment rate by contractor, provider and benefit type. The contractor error rates from this program will be incorporated into CMS long-term strategic goal (Question #1 - Goal #2). The CERT program will allow them to address issues raised in question #3, since CMS plans to require contractors, its main partners, to commit to the error rate goals established through the CERT program. CMS is also attempting to address the issues raised in question #6 by testing methodologies to tie payments to performance through the Performance Based Outcomes Pilot.	CERT - CMS has already released contractor specific error rates for its durable medical equipment (DMERC) regional carriers. It has also committed to long term and annual goals based on contractor error rates. Performance Based Outcomes Pilot - CMS is currently running a small study (3 sites with a total admin budget of approximately $80 million - total CMS contractor budget is approximately $1.2 billion) that will evaluate contractors on 24 different performance criteria and pay an award fee worth up to 4 percent of the contractors budget. At least one of these criteria will be the contractor error rate. CMS has also proposed legislation that would allow it to competitively bid for contractors, allowing them much more leverage to pay for performance.	14%	0.1
Total Section Score					**100%**	**71%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section III: Program Management (Yes,No, N/A)						
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	CMS collects different types performance data to support its long-term goals. The CERT program will provide CMS with very detailed information about payment error rates. Additionally, CMS collects volume data from contractors on claims paid, denied, reviewed, etc. Beginning in 2002, CMS conducted a Program Integrity Customer Service Survey designed to gain more insight into the perceptions of both beneficiaries and health care providers regarding specific program integrity-related services they received. In addition, each year, CMS undertakes a substantive test of its claims payment system in order to determine compliance with Medicare laws, regulations and guidance.	The CERT program is using an representative sample of claims to establish national, contractor, provider type, and benefit category error rates. CMS has also developed a program integrity customer service action plan aimed at improving the service provided by MIP contractors.	13%	0.1
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The CMS Administrator is currently held accountable for achieving the national error rate goals set out for CMS. Additionally, program partners such as FIs and contractors are currently held to process goals related to their cost contracts. Their accountability will be strengthened significantly by CERT. Under the CERT program, FIs and carriers will be held to attaining their contractor specific goals.	The CMS Administrator's performance plan includes the national error rate goal. Additionally, CMS has committed to a long term strategic goal of reducing all contractor error rates to the national rate or below by 2008 (see Strategic Management, question #1)	13%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	73 percent of MIP funds are obligated on October 1. The lapse rate for MIP appropriations is 1 percent. All CMS administrative expenditures are approved by an internal Financial Management Investment Board (FMIB) to ensure that expenditures are consistent with CMS appropriations.	Assessment based on status of funds report.	13%	0.1
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	By statute, CMS currently contracts with FIs and carriers on a cost basis for claims processing. Additionally, they budget most of the MIP funds for FIs and carriers based on activity level (e.g. number of claims subject to a medical review). PSC contractors, in contrast, are competitively bid and are eligible for an award fee if they achieve certain performance targets, some of which are efficiency targets.	By statute, CMS is required to contract with FIs and carriers on a cost basis. HHS has proposed legislation for contractor reform which would, among other things, allow CMS to competitively bid for contractors. This authority would allow CMS to achieve greater efficiencies and performance in claims processing and reducing payment errors, fraud and abuse.	13%	0.0
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	N/A	MIP funds are direct spending, limited by statute. Funding for program operation comes from CMS' discretionary account. The law prohibits using MIP funds to pay for CMS staff.		0%	

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Does the program use strong financial management practices?*	Yes	Medicare has received a clean opinion on its Chief Financial Officer Audit for the past 3 years.	Assessment based on CFO audits	13%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	CMS has proposed contractor reform legislation that would allow it to competitively bid contracts for claims processing. This authority would allow CMS to select contractors with exceptional payment accuracy rates and hold contractors accountable for achieving accuracy goals. Absent this authority, CMS is pursuing the Performance-Based Outcome Pilot discussed in Section 2, question 7.	Contractor reform legislation was most recently proposed in the President's FY 2003 budget.	13%	0.1
8 (B 1.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	CMS closely monitors contractors, providing guidance for claims processing and fraud and abuse activities. CMS staff review contractors plans for fraud and abuse activities. Additionally, CMS Regional Office staff closely oversee the day-to-day activities of Medicare contractors through reviews and audits.	CMS monitoring of contractors is documented in the Regional Office manual, and is also evident by the organizational structure of the MIP program and the Regional Offices.	13%	0.1
9 (B 2.)	*Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	CMS collects different types of performance data to support its long-term goals. Presently, it collects volume and performance data from contractors to manage the cost contract . More importantly, its new CERT program will provide CMS with very detailed information about payment error rates. Additionally, Beginning in 2002, CMS conducted a Program Integrity Customer Service Survey designed to gain more insight into the perceptions of both beneficiaries and health care providers regarding specific program integrity-related services they received.	Examples of the data contractors submit to CMS include claims paid, denied, reason for denials, etc. Valid CERT program results for DMERCs have been released, and CMS is on track to toll out the program in 2004. CMS has created a customer service action plan based on the results of the customer service survey.	13%	0.1
Total Section Score					**100%**	**88%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section IV: Program Results		**(Yes, Large Extent, Small Extent, No)**				
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Large Extent	The program has extended its national error rate goal through 2008 and adopted two new goals that measure contractor error rates and provider compliance. CMS has made significant progress toward achieving its national error rate goal and is on track to complete the CERT program, which will provide them with significant new management data to assist them in attaining their 2008 goal. They are also on track to complete the development of the contractor and provider compliance rate baselines.	As noted below, CMS has reduced the national error rate by over 50% since 1996, demonstrating significant progress towards their long-term goal of 4 percent by 2008. Thus, although they missed by a small amount their FY 2001 goal of 6 % (actual = 6.3%) their overall progress is very strong. CMS has also shown progress towards developing the contractor error rates, releasing DMERC error rates in Sept 2002.	20%	0.1

Long-Term Goal I:	Reduce Medicare's National Fee-For-Service Error Rate
Target:	4 % by 2008
Actual Progress achieved toward goal:	CMS has reduced the national error rate from 14 percent in 1996 to 6.3 percent in 2001. Additionally, its new CERT program will allow it to better target problem areas by contractor, provider, and/or benefit level.
Long-Term Goal II:	Reduce All Contractor Error Rates
Target:	Every contractor will have error rates at or below the national rate by 2008
Actual Progress achieved toward goal:	CMS is still developing the CERT baseline, but is on target to produce contractor specific error rates by 2004. CMS has already released contractor specific error rates for all DMERCs.
Long-Term Goal III:	Reduce Provider Compliance Error Rates
Target:	Reduce the Provider Compliance Rate by 20 percent annually from FY2005-FY2008
Actual Progress achieved toward goal:	CMS is still developing the provider compliance baseline, but has committed to reducing the provider compliance error rate by 20 percent per year for FY2005-2008

2	*Does the program (including program partners) achieve its annual performance goals?*	Yes	CMS has significantly reduced the national error rate since the baseline was set in FY 1996. It exceeded both its FY99 and FY00 goals, and missed its FY01 goal by only a very small margin (however, CMS set aggressive goals for itself - committing to reduce the error rate by 33% from FY 99 to FY01, from 9% to 6%)	CMS has met or exceed its target for FY99 (7.97 % vs. 9% target) and FY00 (6.8% vs. 7% target) and came very close to its FY01 target (6.3% vs. 6% target)	20%	0.2

Key Goal I:	Reduce Medicare's National Fee-For-Service Error Rate
Performance Target:	Reduce Medicare's National Fee-For-Service Error Rate to 5% by 2004
Actual Performance:	as met or exceed its target for FY99 (7.97 % vs. 9% target) and FY00 (6.8% vs. 7% target) and came very close to its FY01 target (6.3% vs. 6% t
Key Goal II:	Reduce All Contractor Error Rates
Performance Target:	Set contractor error rate baseline in 2004
Actual Performance:	CMS is still developing the CERT baseline, but is on target to produce contractor specific error rates by 2004. CMS has already released contractor specific
Key Goal III:	Reduce Provider Compliance Error Rates
Performance Target:	Set Provider Compliance Rate baseline in 2004
Actual Performance:	CMS is on track to produce baselines in 2004

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Small Extent	As mentioned in the program management section, PSC contracts are competitively bid. Cost effectiveness is a factor in each bid, and, furthermore, PSCs are eligible for an award fee if they achieve certain performance targets, some of which are efficiency targets. However, CMS is required by statute to contract with FIs and carriers on a cost basis for claims processing. These contractors make up by far the majority of MIP spending. Additionally, they budget most of the MIP funds for FIs and carriers based on activity level (e.g. number of claims subject to a medical review).	PSC contractor award fees are based on a number of efficiency goals, such as timeliness of responses to law enforcement and beneficiary requests, and acceptance of fraud cases by law enforcement. Contractor reform legislation allowing CMS to competitively bid claims processing would enable CMS to achieve greater efficiencies in program integrity efforts.	20%	0.1
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Yes	Very few other health care or health care payment integrity programs measure their success at paying claims correctly. CMS is a front runner in both the public and private sector at measuring and achieving success at reducing health care claims payment errors.	Other health care programs are in much earlier phases of measuring their error rates. The FBI and HHS OIG use measures of successes that are not directly comparable with MIP, such as expected recoveries from health care cases. (It is important to note, though, that the OIG and FBI are critical to helping CMS achieve success in this area.) Private sector health care insurers either do not directly measure improper payments or do not publicize this information (according to a recent benchmarking study completed by KPMG). CMS, conversely, has been measuring and reducing improper payments since 1996.	20%	0.2
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Yes	CMS's success in reducing the improper payment rate is measured annually by the HHS OIG's calculation of the FFS improper payment rate. (This will be calculated by a PSC contractor going forward.)	OIG has measured the improper payment rate since 1996. The FY 1996 rate was 14%, or $23.2 billion. The FY 2001 rate was 6.3%, or $12.1 billion.	20%	0.2
Total Section Score					**100%**	**80%**

OMB Program Assessment Rating Tool (PART)

Competitive Grant Programs

Name of Program: National Health Service Corps

Section I: Program Purpose & Design (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	There is a consensus of program purpose among interested parties on the National Health Service Corps and the program has a clear and relatively straightforward mission. The overarching goal of the program is to improve care in underserved communities by placing health professionals in selected areas. The program's immediate purpose is to place health care practitioners in underserved areas through a combination of scholarships and loan repayments. In exchange for this support, practitioners agree to serve for a minimum of two years. The program places primary care, oral and mental and behavioral health clinicians in underserved areas. The agency also determines the health professions shortage area (HPSA) definitions and designations. HPSA designation is used for its own purposes and as a funding guide for other Federal programs. The exact purpose of the NHSC field program, which focuses on recruitment, outreach and technical assistance to communities, is less clear.	The National Health Service Corps was first authorized in 1971 (section 331-338 of the Public Health Service Act). Agency and Congressional reports related to the program are consistent with the program purpose as outlined in the authorizing legislation. The program is run by the Health Resources and Services Administration (HRSA).	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The program addresses the problem of communities that have too few primary care, dental, mental and behavioral health care providers. National shortages are relative and subjective, but there is ample evidence that having limited access to a healthcare provider in a community is a barrier to care in and of itself. There are regions and pockets of the country that face shortages of physicians and other healthcare providers known as health professions shortage areas (HPSA). The HPSA designation criteria includes primary medical care, mental health, and dental care. These shortages limit access to healthcare in these areas regardless of the availability of health insurance. By definition, the places where the NHSC clinicians must serve are areas of need.	The February 2002 update of shortage areas prepared by the agency includes 2,781 primary medical care, 798 mental health, and 1,580 dental HPSAs, and 56 million people living in a primary medical care HPSA. The agency estimates that as of August 2000, 26,657 clinicians would be needed to meet desired ratios in these underserved areas, assuming a perfect distribution of those clinicians.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The program is designed to have a significant impact in the context of all other factors that is reasonably known and can be measured. The program is designed to target areas of greatest need for primary medical care, mental health and dental clinicians. As a condition of scholarship or loan repayment, the program places clinicians in shortage areas. The program also maintains a list of communities that are eligible to receive a NHSC provider. This list is available to non-NHSC physicians and visiting physicians on J-1 visas who may also seek to work in the designated community.	Over 30 years, the NHSC has placed over 22,000 clinicians in shortage areas. Currently, 2,366 clinicians serve in every State, the District of Columbia, and territories. The Office of the Inspector General found in 1994 that 90% of facility directors believe their facility could not adequately serve patients without NHSC providers. As of August 15, 2002, there were 2,434 sites listed as eligible to receive a NHSC clinician.	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	Under a strict interpretation, the NHSC is the only Federal program that provides a financial incentive directly to providers as a means of improving access to health care in specific communities. The mechanism and point in the process at which they engage with the provider varies from other Federal programs that share the goal of improving the distribution of health care providers. A separate but related HRSA program, the Health Professions, includes as one of its principal aims to improve access to care in medically underserved communities by improving the distribution of health care providers.	The GAO noted in 1995 the NHSC is the Federal government's main program for placing physicians and other providers in health professions shortage areas. The Council on Graduate Medical Education also notes the program is "specifically designed to address geographic maldistribution." The Nursing Education Loan Repayment and Scholarship Program offers similar support, but only for registered nurses. Title VII health professions programs aim to improve the distribution of health care providers by providing training grants and other support to students and institutions.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The program is administered through scholarships and loan repayments paid directly to the provider. Given a cost differential, greater flexibility in the allocation of funds between loans and scholarships and by discipline can improve program efficiency. NHSC providers were Federal employees until 1980. The majority are now employed by the facility in which they practice.	There is no evidence that a block grant to states, tax incentive, regulation or other mechanism would be more efficient or effective in addressing the problem. With respect to the more narrow issue of scholarships versus loan repayments, a 1995 GAO report recommended loan repayments above scholarships as a more cost effective means of placing providers.	20%	0.2
Total Section Score					**100%**	**100%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning		**(Yes, No, N/A)**				
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	The program adopted new long-term goals during the assessment process. The long-term goals focus on increasing access to the nation's neediest populations through the placement and retention of NHSC clinicians and the placement of independent physicians through other program efforts.	The program has two long-term goals with targets: 1) Increase by 20% by 2010 the number of individuals served among the Nation's neediest populations through the placement and retention of NHSC clinicians; 2) Increase by 20% the number of individuals served in all communities seeking NHSC assistance. (This measure also captures placement through other sources resulting from NHSC involvement.)	17%	0.2
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	During the assessment process, the program has adopted new annual performance goals that would demonstrate progress toward desired long-term outcomes.	The first goal captures how well the program is extending its reach by retaining NHSC providers in service after the end of the contract period. The second goal captures how well the program is targeting the most needy communities by measuring the severity of the physician shortage in communities based on their HPSA rating. The third goal captures additional program efforts to help communities by measuring the percentage increase of NHSC vacancies filled through all sources. These sources can include private matches, J-1 visas and other entries to employment.	17%	0.2
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	NHSC clinicians commit to a period of service in a designated area in return for financial incentives in the form of scholarships and loan repayments. The clinicians are held liable if they breach the contract by failing to fulfill their service commitment. The majority of clinicians continue to serve even after the required period. This commitment to a minimum period of service and often times longer period of service supports the program's annual and long-term goals. Additional partners include the health care delivery sites that are eligible to recruit NHSC supported providers. By definition, these partners share the goal of placing providers in underserved areas.	If this contract is breached, participants will be liable to pay the total amount of loan repayments paid and an obligation penalty of up to $24,000. A NHSC scholar who fails to begin or complete service is liable for up to three times the amount received plus interest. In 2000, 75% of NHSC clinicians who fulfilled their service commitment continued to serve under served populations. In addition to the service commitment, the program encourages extended service through newsletters, list serves and personal contact with the providers.	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	The NHSC has significant room for increased meaningful collaborations outside of the Federal government, but recent NHSC budget requests have reflected a meaningful budget and management actions in response to the health center initiative. Guidance for this question states a Yes would require that the program show evidence of collaboration leading to meaningful actions in management and resource allocation. Similar management and budget changes within the health centers program have not been made. The program is based on a "one community at a time" approach to improving access to health care, and may be able to further its impact by more aggressively partnering with other entities to encourage providers not receiving NHSC support directly to practice in designated areas. In addition, further collaboration with other Federal activities that share similar goals such as the Health Professions grants may be beneficial.	The program is in contact with underserved communities designated as eligible for NHSC providers, consolidated health centers, state-based entities, professional organizations, and academic institutions. The program is associated with the Consolidated Health Centers initiative, and budget formulation and planning seems to reflect the connection between the two programs. An example of budget actions includes an emphasis on directing loan repayments to staff health centers expanded by the health centers initiative.	17%	0.2
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	Evaluations have been conducted on an average of once every five years. These evaluations include information on program performance and have recommended changes to the program. The agency plans to support additional evaluations in the future to obtain updates on program effectiveness, including retention of NHSC clinicians after the period of required service. More focused evaluations that also include effectiveness information are conducted by third parties on a more ad hoc basis.	The latest evaluation was published in May of 2000 and was conducted by the University of North Carolina at Chapel Hill and Mathematica Policy Research, Inc. under contract with the agency. In addition, GAO has reported on the program and provided information on program effectiveness.	17%	0.2
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	Yes	The program can estimate the associated cost of each field placement, which is directly associated with the program's outcome goals. While the program's annual budget display does not meet all standards of alignment, the program's ability to attribute cost to each output is sufficient to meet the standards of this question. The program budget structure is fairly straightforward and clear and does not vary markedly from program goals. The agency is working to tie budget planning to strategic planning. The program can estimate outputs (number of placements) per increased increment of dollars, and the distribution of funding between scholarships and loan repayments is specifically designated in the authorizing legislation. The program surveys retention rates and can also estimate the impact of funding changes on the total directly supported and retained workforce. Program management funds are budgeted elsewhere.	This assessment is based on the annual budget submission to OMB and the Congress, and other information provided by the agency. The annual output is the field strength of the NHSC through scholarships and loan repayment agreements. By statute, the program knows the annual allotment between scholarships and loan repayments.	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	NA	The purpose of this question is to give credit where programs are not meeting the standards for a Yes to questions in this section, but are taking steps to correct those specific deficiencies. The main deficiency related to this section had been in setting long-term goals. Given the program has adopted meaningful long-term goals, this question is rated as not applicable and the points are redistributed. Related to strategic planning, the agency overall is making organizational changes which will further integrate budget and performance planning. Additional work is also needed to enhance opportunities for meaningful collaboration. The agency reorganized its operations to organizationally fold the program in with the Health Professions. The program adopted a performance measure that tracks the number of community placements filled by other sources. These steps should greatly enhance opportunities for meaningful collaboration between related state and Federal partners, and between the NHSC and Health Professions.	The assessment is based on discussions with the agency. The agency's electronic data system can also improve the use of performance information in budgeting and planning. An agency management reform effort transferred the NHSC and the office charged with developing HPSA designations from the Bureau of Primary Health Care to its sister entity, the Bureau of Health Professions. The restructuring puts a single bureau in charge of all health professional programs.	0%	
Total Section Score					**100%**	**100%**

Section III: Program Management (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	The program collects and reports on information annually on the field strength and short-term retention of NHSC clinicians. The program collects information from scholars during training and service and annually collects data from communities regarding services performed. The program uses this information to improve selection and placement, help scholars through the training period, ensure clinicians meet their service requirements, and design efforts to increase retention after the period of required service.	Annual performance reports, service verification form, National Health Service Corps Uniform Data System reports.	9%	0.1
2	*Are Federal managers and program partners (grantees, sub grantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The agency's senior managers are held accountable for operations of their programs, including performance results, through their annual performance contracts. Program partners are held accountable through penalties for breach of contract.	The Administrator's performance contract includes an outcome target for the NHSC. If NHSC loan repayment clinicians breach their contract, they are liable to repay their subsidy, plus a penalty of up to $24,000. A NHSC scholar who breaches his/her scholarship service commitment is liable for three times the amount received, plus interest, prorated for partial service.	9%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	Scholarships and loan repayments are awarded annually with sufficient time to shift awards to alternates in the event a potential recipient declines the award. Scholarship awards are made in August to conform to the school year. Loan repayment contracts are made in September after the new HPSA designation scores are available. The program monitors placements to ensure clinicians remain in eligible service areas.	Assessment based on apportionment requests and annual budget submissions.	9%	0.1
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	In general, there is little evidence that the program has incentives and procedures in place to improve efficiency and cost effectiveness in program execution. The program does contract out some services.	Contracted services include scholarship support, technical assistance, marketing and outreach, logistics and filing.	9%	0.0
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program does not capture all direct and indirect costs borne by the program agency, including applicable agency overhead, retirement, and other costs budgeted elsewhere. The program does not have a procedure for splitting overhead and other costs between outputs, including scholarships and loan repayment, or include informational displays in the budget that present the full cost of outputs.	The assessment is based on annual budget submissions to OMB and Congress. The program does not have an agency program budget estimate that identifies all spending categories in sufficient detail to demonstrate that all relevant costs had been included or a report that shows the allocation of overhead and other program costs to the program. Overhead and other program costs, including FTEs, are included in the field budget.	9%	0.0
6	*Does the program use strong financial management practices?*	Yes	HRSA received its first clean audit in 1999.The 2000-2001 agency financial statements showed no material weaknesses. HRSA financial statements are conducted by the Program Support Center. The IG found in a 2002 audit of HRSA's travel, appointments, and outside activities that there was no evidence of substantive violations, but that there are technical lapses requiring improvement. The agency disagrees with the breadth of the problem and has re-issued guidance to improve oversight.	The assessment is based on agency financial statements and IG audits. The program maintains procedures to detect if NHSC clinicians are out of compliance with program requirements.	9%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	The main deficiencies in this section include incentives and procedures to improve efficiency, and the development of the full annual cost of operating the program to achieve desired performance. The agency is taking meaningful steps to correct these deficiencies. One potential barrier to the program's efficiency in meeting the goals is the ability of providers not to serve the target population if they take advantage of the national research service award option.	The program is working with a consulting firm to reengineer its business processes. The program is also in the process of examining competitive sourcing options. The program anticipates completing the transition to an electronic system for the applications for community sites, scholarships, and loan repayments by the end of the 2002 calendar year. The program is also examining ways to stretch Federal loan repayment investments by adjusting maximum repayment levels for an individual clinician in the second and third years.	9%	0.1
8 (Co 1.)	*Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?*	Yes	While not peer reviewed, the process for making loan repayment and scholarship awards is competitive and fair and is based on clear criteria including those established by law. Determining what facilities should be eligible for NHSC providers can be a subject of debate, but the program has a clear and consistent approach for making those designations.	The criteria to determine whether a community is eligible to receive a NHSC supported clinician require that the health care facility be located in a federally designated HPSA, document sound fiscal management, use a sliding-fee schedule or other documented methods to reduce fees that ensure no financial barriers to care exist, accept assignment of Medicare, enter into an agreement with the State agency that administers Medicaid, and produce proof of the capacity to maintain a competitive salary, benefits, and malpractice coverage package.	9%	0.1
9 (Co 2.)	*Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	Yes	The NHSC supports an annual recruiting effort through print and radio advertising, direct mail, and communication with schools, communities and other Health Professions programs to encourage new clinicians. The application is open to all scholars and clinicians who meet the legal requirements, and the majority of awards are made to first time applicants.	Between 85-90% of scholarships and between 55-70% of loan repayments for each of the last few years have been new awards. The program has found It difficult to recruit a diverse workforce for the NHSC due to the overall composition of the health professions student body.	9%	0.1
10 (Co 3.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	Scholars are monitored throughout the training process directly and through the school to verify compliance with legislation, regulations and programmatic issues, and checked monthly prior to payment of awards. Loan repayment clinicians are monitored using six month verification checks, periodic phone calls to the site, and site visits from HRSA field office staff.	The program conducts financial audits of scholars, including stipends, tuition and other costs expended. Upon completion of study, program participants fulfill the service commitment by obtaining employment at an approved facility for their discipline or through a National Research Service Award.	9%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
11 (Co 4.)	*Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	NHSC clinicians and partner facilities provide data annually to the agency. The program uses End of Service Surveys and the Uniform Data Set to collect information on the care delivery and retention of NHSC clinicians. Annual performance data are summarized in the performance report and made available on the agency web site. On a less systematic basis, performance data are also presented at conferences and other public presentations. The names of those who breached their contract are not provided to the public.	Assessment based on agency GPRA reports and web site (www.hrsa.gov).	9%	0.1
Total Section Score					**100%**	**82%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	No	The program has developed new long-term goals for the program to measure outcomes. The program tracks the immediate field size of the NHSC through scholarships and loan repayment agreements and surveys retention rates of those who completed the program. The long-term outcome goals measure the impact of the program based on the amount of care provided by current and retained providers. Once data showing this impact are available, the program can be rated from between a Small Extent to a Yes.	The baseline year for these goals is 2001 and no baseline data exists for newly developed goals. The program will adjust its data collection efforts to accurately record and report on new goals. Targets are based on assumptions and will be adjusted, if necessary, once baseline data are available.	20%	0.0

Long-Term Goal I:	Increase the number of people served through the placement and retention of NHSC clinicians. (new measure)
Target:	20% by 2010
Actual Progress achieved toward goal:	Baseline under development.
Long-Term Goal II:	Increase the number of people served in all communities seeking NHSC assistance through NHSC placement, retention and other sources. (new measure)
Target:	20% by 2010
Actual Progress achieved toward goal:	Baseline under development.
Long-Term Goal III:	
Target:	
Actual Progress achieved toward goal:	

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program (including program partners) achieve its annual performance goals?*	Small Extent	The program developed new annual goals that will measure progress toward its long-term outcomes. Performance data available from previously held goals and survey information that relate to these new measures are available and indicate results that contribute to the long-term outcomes of the program. Targets for FY 2004 are still under review.	Relevant performance data related to the new goals include, in FY 2002, the current NHSC field strength increased 14% to 2,703. In FY 2001, the percent of NHSC clinicians retained in service increased from 75% to 80%. Data are not yet available on HPSA scores and vacancies filled through all sources. A large extent would require data that show progress on these other measures. The program's annual goals capture not only the number of physicians directly supported by Federal investments, but also the number retained after the service contract is complete and the number of communities the program works with that are able to recruit physicians through other channels.	20%	0.1

Key Goal I:	Increase the number of people served in the nation's neediest communities through the placement and retention of NHSC clinicians. (new measure)
Performance Target:	2.5% by 2004
Actual Performance:	Baseline under development.
Key Goal II:	Increase the average Health Professional Shortage Area (HPSA) score of areas receiving NHSC clinicians, an indicator of provider shortages and the extent to which the program targets communities of greatest need. (new measure)
Performance Target:	1% by 2004
Actual Performance:	Baseline and target under development.
Key Goal III:	Increase the number of NHSC-list vacancies filled through all sources. (new measure)
Performance Target:	1% by 2004
Actual Performance:	Baseline and target under development.

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Small Extent	The program received a No in Question 4 of Section III, and according to guidance is not eligible for a full Yes to this question. By the end of FY 2002, the program had converted 14 of its Federal full time equivalent positions previously serving in administrative and other support roles into NHSC providers through a first responders initiative. This change will increase the number of NHSC clinicians within the current year totals. A Yes or Large Extent would be appropriate with additional incentives in place and as this conversion continues, if the conversion of FTE translates into improved cost effectiveness in achieving program goals. As noted previously, the agency finds as its primary barrier to increasing efficiency the inability to shift resources further from scholarships to loan repayment awards. Additional work is also needed to better target NHSC providers in areas of highest need.	The program announced in April of this year that it is recruiting clinicians to serve as commissioned officers of the U.S. Public Health Service within the NHSC. The clinicians will be classified as Ready Responders within the NHSC and would eventually include 36 family practice physicians and four dentists who will be assigned for 3 years in a HPSA. These 40 positions are to be absorbed by the program through reduction of FTE for administrative and other program support positions. With respect to the balance between scholars and loan repayments, 79% of NHSC loan repayment clinicians serve in an underserved area after the required period of service compared to 62% NHSC scholars. NHSC loan repayment costs per clinician placement per year of promised service are one half to one third as much as the scholarship costs.	20%	0.1
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Yes	The program is not involved in the Federal government's Health Common Measures (for information on these measures see www.whitehouse.gov/omb). The NHSC's sister program, the Health Professions, does not provide a direct comparison, but shares the goal of improving the distribution of health professionals. Relative to the Health Professions, the NHSC is a more direct mechanism for improving the distribution of health professionals and based on annual performance data is more efficient in its rate of placements. When considering the ability of the NHSC to show retention of its clinicians in shortage areas, the performance of this program compares favorably.	Dollar for dollar, the NHSC is more efficient in placing medical professionals in shortage areas than the Health Professions. According to the most recent data available, in 2000 the average cost per placement was $77,400 for the Health Professions and $47,900 for the NHSC. According to the National Conference of State Legislatures, most state scholarship and loan repayment programs have not been evaluated, and thus have no evidence of their effectiveness.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Large Extent	Recent evaluations indicate the program is effective. A 2000 Mathematica evaluation found the program is effective in providing underserved communities with clinicians. The evaluation found low satisfaction in the matching process, but increasing effectiveness in recruiting individuals motivated by a more altruistic desire to practice in underserved communities, a factor that can improve long-term retention. Earlier evaluations were more mixed. A 1995 GAO report found the program is working, but placed more providers than needed in some areas and none in others, did not have the most effective mix of loan repayments and scholarships, and needed improved coordination with J-1 visa waiver process. A 1995 University of Washington survey of rural scholars found half remain in service long-term. A 1994 HHS OIG report found facilities receiving NHSC clinicians depend on them to adequately serve patients, but certain procedures needed improvement. A 1994 JAMA study found low morale and poor retention among rural NHSC physicians in the 1980s.	The 2000 evaluation found long-term retention of up to 15 years of NHSC providers after the required period of service is 52%. The evaluation also found overall NHSC clinicians and alumni reach new patient populations, increase the volume of services, add new services and may often play a role in initiating community-oriented primary care programs. With respect to the mix of loan repayments and scholarships, the GAO report states loan repayments are more cost-effective and produce clinicians more likely to complete their obligation and remain in service, however, the program must dedicate at least 40% to scholarships by statute.	20%	0.1
Total Section Score					**100%**	**47%**

OMB Program Assessment Rating Tool (PART)

Competitive Grant Programs

Name of Program: Nursing Education Loan Repayment and Scholarship Program

Section I: Program Purpose & Design (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	There is a general consensus that the specific purpose of the program is to increase the number of nurses serving in facilities that face challenges with recruitment and retention. Program managers view the program as a way to help place nurses in specific facilities where they are most needed to improve care. Some views expressed by interested parties indicate a more broad purpose of addressing a nursing shortage. The program repays up to 85% of the principal and interest of any qualified nursing education loans loan for nurses in return for up to three years of service in an eligible health facility. Eligible nurses are those who received a baccalaureate or associate degree in nursing, a diploma in nursing, or a graduate degree from an accredited school of nursing. New 2002 authorizing legislation broadens the type of facilities eligible to receive a nurse supported by the program, establishes a scholarship component and renames the program the Nursing Education Loan Repayment and Scholarship Program. The program is part of a Department of Health and Human Services Secretarial Initiative.	The Nursing Education Loan Repayment Program was amended in 1998 and again in 2002 (section 846 of the Public Health Service Act). Agency and Congressional statements related to the program are consistent with the program purpose as outlined in the authorizing legislation. The program had been authorized to place registered nurses specifically in community health centers, Native American and Native Hawaiian health centers, public hospitals, rural clinics, and public or private nonprofit health facilities with a critical shortage of nurses. The Nurse Reinvestment Act of 2002 expanded eligible facilities to include any health care facility with a critical shortage of nurses, including private for-profit facilities, and gives preference only based on the financial need of the applicants. The new legislation also establishes a nursing scholarship program. The program is run by the Health Resources and Services Administration (HRSA).	23%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The program is designed to address the problem of nurse vacancies and low ratios in health facilities. The program addresses the problem of shortages by providing funds directly to nursing graduates who agree to provide care in a facility with a critical shortage of nurses. Shortages are a fairly subjective measure, however, evidence from the program and others suggest an insufficient number of nurses in place and in training. There is evidence of more acute shortages in specific health care facilities. By giving preference by financial need, the program maintains an equity element to support those nurses with the greatest financial burden.	Nursing is the single largest health profession. Projections from HRSA indicate a shortage of 110,000 registered nurses in 2000 (a national supply of 1.89 million nurses and demand of 2 million) and an estimated shortage of 800,000 by 2020. The Bureau of Labor Statistics is also projecting a shortage of nurses. The American Hospital Association reports 75% of hospital vacancies are for nurses. GAO reports the national unemployment rate for RNs was 1% in 2000. Nursing impacts the quality of care. Researchers have found higher levels of nursing care provided by registered nurses are associated with better care for hospitalized patients.	23%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	No	In its current form, the program is not designed to have a significant impact on the problems of nursing distribution and supply. However, the weighting of this question is reduced because the main impediment to having a significant impact is the program's size, which is not merely a factor of program design. The program provides a direct financial incentive for registered nurses with student loans to enter service in any health care facility facing a nursing shortage. By placing nurses in facilities facing a shortage, the program could have an impact on the problem of the distribution of nursing professionals. The program was first designed to be relatively small. The agency does not have data on the number of facilities that are eligible under the current authorization, but the new design captures a broader list of potential entities. For example, the new definition can include hospice centers, nursing homes, and other facilities in addition to hospitals, health centers and other clinics.	According to the National Sample Survey of Registered Nurses, hospitals, public and community health settings, ambulatory care settings, and nursing homes and extended care facilities are the main employment settings for nurses. Facilities with a critical shortage of nurses that have been added to the new authorization include: public health clinics, ambulatory surgical centers, home health agencies, hospices and skilled nursing facilities. For profit entities are eligible until 2007 under the new authorization. This list captures thousands of health care facilities. In its current form, the program is supporting only 560 contracts. The program received approximately 6,000 requests for applications in FY 2002. Multiple other factors nurses report as reasons for leaving the profession that the program is not designed to address include direction over patient care, workload, support staff, salaries and hours. The program is now authorized at such sums as necessary, but was authorized at $5 million in FY 1993 and $6 million in FY 1994.	10%	0.0
ırpose & D	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	The Nursing Education Loan Repayment and Scholarship Program is the only Federal program that is designed to provide a financial incentive directly to registered nurses to send them into shortage facilities as a means of improving access to health care in public and private settings. The NHSC supports advanced practice nurses that serve as primary care providers, and not RNs in direct nursing. Private foundations and professional associations, along with some state governments, offer scholarships to encourage students to enter study in nursing. The focus of this program is to improve the distribution of the existing registered nurse workforce.	Nurse practitioners and certified nurse-midwives are also eligible for support through the National Health Service Corps (NHSC) loan repayment and scholarship programs in exchange for service in a shortage area. The Department of Veterans Affairs' National Nursing Education Initiative offers scholarships for registered nurses who return to school to attain baccalaureate and advanced degrees, but only for those nurses in service to the VA. The Army, Navy and Air Force also support nursing scholarships, but in exchange for service in the military.	23%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The program provides direct payments to registered nurses in exchange for serving in a facility facing nursing shortages. Aspects of the program design will have an impact on the focus and efficiency of the program. Unlike the National Health Service Corps (NHSC), the program is focused on eligible health care facilities with a shortage of nurses, rather than geographic areas, and does not focus on sites that serve patients with multiple barriers to care. However, unlike the NHSC, the program authorization leaves the allocation between scholarships and loan repayments up to the discretion of the Secretary.	There is no evidence that a block grant to states or other mechanism would be more efficient or effective in addressing the problem.	21%	0.2
Total Section Score					**100%**	**90%**

Section II: Strategic Planning (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	The program has adopted new long-term measures that are useful and capture important elements of program impact. Selecting a measure of impact on a large problem is difficult for a small program such as this one. As the program matures, further work may be needed to improve the measurement of key outcomes. The program's first measure tracks the impact of the program on increasing student enrollment in nurse training programs. Increasing enrollments in nursing is important to stave off an anticipated nursing shortage and help improve shortages within specific types of health care facilities. The addition of a scholarship component may serve as an additional incentive to encourage students to pursue careers in nursing. The program's second and third goals track placement and retention, and by themselves do not constitute true outcome measures.	The program's long-term measures are useful but focus mostly on outputs. The third measure relates to program impact by capturing the portion of participants who continue to serve after the end of the contract. The program's long-term measures include: 1) Increase by 10% by 2010 the number of individuals enrolled in nursing training programs; 2) Increase to 25% by 2010 the proportion of program participants working in priority shortage facilities such as: disproportionate share hospitals for Medicare and Medicaid, nursing homes, public health departments (state or local) and public health clinics contained in these departments; 3) Increase to 12% by 2010 the proportion of program participants who remain employed at a critical shortage facility for at least one year after they have fulfilled their service contracts.	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	During the assessment process, the program has adopted annual output measures that would demonstrate progress toward desired long-term outcomes. These goals are in addition to the GPRA goal previously used that tracked the annual number of contracts.	The annual goals measure the number of nurses supported by the program, the percentage who extend their contract, and the percentage who remain in service a year after no longer receiving support.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	Program partners include the participating RN's, the facilities that are identified as eligible for the program, lending agencies, and the loan verification and application contractors. Nurses supported by the program commit to a period of service in a health care facility in return for financial incentives in the form of loan repayments, and in the future also scholarships. The program maintains contact with recipients, verifies loan balance information with lending agencies and verifies employment with employing agencies through the contract period.	The employer verification is completed by the employer every six months and indicates employment status and salary. Loan verification includes an initial credit check for Federal loan defaults and a status check with the lender every six months. The program is examining ways to measure retention, which is a good indication of recipient support of the long-term goals of the program.	14%	0.1
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	No	The program does not yet have evidence of collaboration leading to meaningful actions in management and resource allocation.	There are examples of the program working with other Federal activities. The program is collaborating with other HRSA units on a nursing HPSA designation and learning from the National Institutes of Health Loan Repayment Program to improve processes to monitor retention.	14%	0.0
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	No	No independent evaluations of the program have been conducted. As described below, the program is to develop an evaluation plan to meet a Congressional requirement to report on results and to further support program improvements.	The program is relatively new and until FY 2001 was funded at less than $2.3 million. No funds were expended out of this amount to contract out an evaluation and no third parties have conducted comprehensive evaluations on their own.	14%	0.0
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	Yes	The program can estimate the associated cost of each nurse placement, which is directly associated with the program's desired outcomes. The program budget structure is fairly straightforward and clear and does not vary markedly from program goals. While the program's annual budget display does not meet all standards of alignment, the program's ability to attribute cost to the key output is sufficient to meet the standards of this question. The agency is working to tie budget planning to strategic planning. The program can estimate outputs (number of placements) per increased increment of dollars. The program does not yet survey retention rates and cannot, however, estimate the impact of funding changes on the total directly supported and retained workforce. Program management funds are budgeted elsewhere. The addition of a scholarship component to the program would require additional effort to align budgeting and planning for the program.	This assessment is based on the annual budget submission to OMB and the Congress, and other information provided by the agency.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	The main deficiencies related to this section are in collaborating with other programs and having planned evaluations. Now that the program has grown, the program plans an independent evaluation of program participants in FY 2004, using data from FY 2001 and FY 2002 awards as the baseline. The agency's electronic data system can also improve the use of performance information in budgeting and planning. The Division of Nursing has a long history and is experienced in collaborating with other Federal programs and the program plans to increase collaboration now that the program is funded at a larger level. The agency overall is making organizational changes which will further integrate budget and performance planning. Additional work is also underway to consider improved long-term outcome measures.	The assessment is based on discussions with the agency. Under the new authority, the program is required to submit a report to Congress within 18 months of enactment that describes numerous aspects of the program's performance, including an evaluation of the overall costs and benefits of the program. The legislation also calls for a report from the Comptroller General within four years of enactment on nursing shortages and hiring practices according to the type of facility, as well as on the impact of the new scholarship program on enrollment in schools of nursing. The program expects the new data collection efforts will allow for an analysis of other program elements such as location of practice, types of facilities served, and retention rates of the nurse recipients.	14%	0.1
Total Section Score					**100%**	**71%**

Section III: Program Management (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	Overall, the program is regularly collecting performance information useful for management. Managers confirm program requirements are being met on a regular basis and this information is current enough to be useful. Collecting timely and credible performance information will be especially critical as the program develops the new scholarship component in order to make resource allocation decisions between the two instruments to maximize program performance. Critical performance data on retention after the two to three year service agreement is not being collected. This data would provide the program useful information on how well it is meeting its long-term goals.	Program staff are responsible for verifying loan payment and employment every six months.	9%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Are Federal managers and program partners (grantees, sub grantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The agency's senior managers will be held accountable for program operations, including results, through their annual performance contracts. The nursing provider only needs to provide a payment history showing the Federal award has been applied to his or her loans in the event of an amendment contract, however, the program also confirms payments directly with the lender. Performance information could be extended to program staff performance evaluations or contracts.	If the contract is breached, participants will be liable to pay the total amount of loan repayments paid plus interest. Unlike the National Health Service Corps, there is no penalty for breach of contract. Currently, payments are distributed monthly through an electronic funds transfer to a checking or savings account that the participant designates. It is the participant's responsibility to see that loan payments are made to the lenders. The program is examining the option of making payments directly to the lender, which could improve accountability.	9%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	Loan repayments are awarded annually with sufficient time to shift awards to alternates in the event a potential recipient declines the award. The program confirms with lenders that loan repayment awards are spent for the intended purpose and is exploring the option of making payments directly to the lender.	Assessment based on apportionment requests and annual budget submissions.	9%	0.1
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	The program has developed a web-based application that it expects will improve program efficiency, data collection, and oversight and analysis by the program staff. As noted in Section IV, these changes have enabled the program to increase their approved contracts to staff ratio. With respect to achieving its goals, the agency predicts a continual increase in tuition costs, which will drive-up the average cost of placing a nurse through the program. Managing the impact on placements per Federal dollar will be an important factor if tuition costs rise quickly.	The program has contracted out specific services, including the development of a web-based application. The agency is exploring competitive sourcing options. The program is also using a new database to collect information on educational preparation, types of facilities, correlation between award and financial need, and the geographic distribution of placements.	9%	0.1
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program does not have a financial management system that fully allocates program costs and associates those costs with specific performance measures. The program has not developed a procedure for splitting overhead and other costs between outputs. The program does not capture all direct and indirect costs borne by the program agency, including applicable agency overhead, retirement, and other costs budgeted elsewhere, or include informational displays in the budget that present the full cost of outputs. Formulation and execution are also not driven by performance goals. Given a budget total, the program can estimate the number and average cost of two and three year loan repayment contracts. For example, with an average cost of a new contract for FY 2003 at $21,000, the program can estimate the number of new contracts that can be funded at a given level.	The assessment is based on annual budget submissions to OMB and Congress. The program does not have an agency program budget estimate that identifies all spending categories in sufficient detail to demonstrate that all relevant costs had been included or a report that shows the allocation of overhead and other program costs to the program. Program managers budget for grants, grant review, travel and technical assistance. Staffing, space, and overhead are budgeted for within the agency program management budget line.	9%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Does the program use strong financial management practices?*	Yes	HRSA received its first clean audit in 1999.The 2000-2001 agency financial statements showed no material weaknesses. HRSA financial statements are conducted by the Program Support Center. The IG found in a 2002 audit of HRSA's travel, appointments, and outside activities that there was no evidence of substantive violations, but that there are technical lapses requiring improvement. The agency disagrees with the breadth of the problem and has re-issued guidance to improve oversight.	The assessment is based on agency financial statements and IG audits. Applicants are not eligible if they have a judgment lien against their property for a debt owed to the United States, have breached an obligation for professional service to a Federal, State, or local government entity, are in default of a Federal debt (e.g., student loans, delinquent taxes, etc.) or are not considered by their creditors to be in good standing.	9%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	The purpose of this question is to register credit where a program does not meet the standards of individual questions in this section, but is taking meaningful steps to address those specific deficiencies. The main deficiencies in this section relate to the development of the full annual cost of operating the program to achieve desired performance and the availability of performance data to the public. The program is actively engaged in developing new goals, which is a key first step for the program to develop the full cost of meeting performance levels. Tracking performance on key outcomes will also enable the program to make meaningful performance information available to the public.	The program is reviewing program policies and procedures related to grant application materials, application review, repayment awards and compliance with program requirements. The program is adopting long-term and annual performance goals, and will be in a better position to advance the alignment of the budget with those goals. The program is also implementing a new electronic on-line application and data reporting system and has taken steps to improve the compatibility of the system with software used by program applicants.	9%	0.1
8 (Co 1.)	*Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?*	Yes	Because it provides loan repayments directly to individual nurses, the program does not use a peer review process for making loan repayment awards. However, the process is competitive and fair and is based on clear criteria including those established by law.	The criteria used to determine the eligibility of a health care facility to receive a nurse now includes only that the health care facility face a nursing shortage. The program also emphasizes financial need of the nurse professionals in the application process.	9%	0.1
9 (Co 2.)	*Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	Yes	By design, the program encourages the participation of new and first-time nurses. The application is open to all nurses with student loans who meet program requirements, and the majority of awards are made to first time applicants.	The program provides application materials on the Internet and allows recipients to submit the application on-line. Nurse professionals are only eligible for a second contract with the program if they have returned to school in nursing and have incurred new student loans. The program received approximately 6,000 requests for applications in FY 2002.	9%	0.1
10 (Co 3.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	The program confirms annually that obligated nurses are serving in approved facilities, and monitors loan debt to insure funds are used for paying down loans.	The program confirms payments directly with the lender and checks with employers to monitor whether the program recipient remains in service in an approved facility.	9%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
11 (Co 4.)	*Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	No	The only annual performance data currently made available to the public is the number of contracts awarded by the program. Important aspects of program performance to be collected and made public in the future include retention rates after the two to three year period of required service, the correlation between actual awards and financial need, and the distribution of nurse professionals by facility and geography.	Assessment based on agency GPRA reports and web site (www.hrsa.gov).	9%	0.0
Total Section Score					**100%**	**82%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	No	The program has adopted new long-term goals for the program. Additional steps may be needed to capture the program's impact on the national problem or on targeted facilities. An additional goal measuring program efficiency is also being considered. A Small Extent, Large Extent, or Yes will require outcome data. The program's existing performance measures provide relatively limited data on past performance toward meeting its long-term goals. However, with the adoption of new annual and long-term goals, the program will be in a better position to track performance in the future. The program includes health departments in the list of key facilities because of the importance of these entities and the critical need for nursing staff there. Retention is an important indicator of program outcomes. The program will track progress on the third measure using a survey of recipients similar to that used by the National Health Service Corps.	The baseline year for these goals is 2001 and in most cases 2002 data are not yet available. The target year for the long-term goals is 2010. Once baseline data are available, the 2010 targets may need to be adjusted.	25%	0.0

Long-Term Goal I:	Increase the number of individuals enrolled nationwide in nurse education and training programs compared with 2004. (new measure)
Target:	10% by 2010
Actual Progress achieved toward goal:	Baseline under development.
Long-Term Goal II:	Maximize the impact of the program by increasing the percentage of participants working in nursing homes, hospitals that provide care to a disproportionate number of low-income patients under Medicare and Medicaid, and public health departments and clinics. (new measure)
Target:	25% by 2010
Actual Progress achieved toward goal:	Baseline under development.
Long-Term Goal III:	Expand the impact of the program by increasing the percentage of participants who remain employed at a critical shortage facility for a year or more after completing their service contract. (new measure)
Target:	12% by 2010
Actual Progress achieved toward goal:	Baseline under development.

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program (including program partners) achieve its annual performance goals?*	Small Extent	The program's existing performance measures provide relatively limited data on past performance toward meeting its annual goals. However, with the adoption of new annual goals, the program will be in a better position to track performance in the future. A Large Extent will require additional data to indicate progress on the annual measures.	Relevant data that are currently available include the number of contracts supported. The program supported 170 contracts in 1998, 202 in 1999, 195 in 2000, 443 in 2001 and 560 in 2002.	25%	0.1

Key Goal I:	Maximize the impact of the program by increasing the percentage of participants working in nursing homes, hospitals that provide care to a disproportionate
Performance Target:	10% by 2004
Actual Performance:	Baseline under development.
Key Goal II:	Reduce Federal investment per year of direct support by increase the proportion of program participants who extend their service contracts and commit to work
Performance Target:	22% by 2004
Actual Performance:	21% in 2001
Key Goal III:	Increase the percentage of nurses supported by the program who remain employed at a critical shortage facility for a year or more after completing their
Performance Target:	10% by 2004
Actual Performance:	Baseline under development.

3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Small Extent	The program met the standards for a Yes in Question 4 of Section III due to steps taken to improve the efficiency of Federal administration. The program is implementing a new electronic on-line application and data reporting system and has taken steps to improve the compatibility of the system with software used by program applicants. There is no evidence of improved efficiency per Federal dollar at the actual loan repayment contract level. The program emphasizes that improved efficiencies per Federal investment will be difficult given rising tuition costs. Efficiencies can be improved with increased retention rates after the period of service.	In 2001, roughly eight staff reviewed 600 applications and awarded 200 loan repayment contracts. In 2002, roughly 18 staff reviewed 5,900 applications and awarded 560 contracts. The only data currently available in the program's annual performance report has been the number of loan repayment contracts. Due primarily to rising tuition costs, the Federal cost per contract increased from roughly $11 thousand in 1999 and 2000 to roughly $18 thousand in 2000. By tracking data on third year extensions and retention beyond the service contract, the program will be better able to measure changes in efficiency in the future that go beyond the increasing size of recipient loan burdens.	25%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	NA	The program is not involved in the Federal government's Health Common Measures (for information on these measures see www.whitehouse.gov/omb). There are no programs of similar size available for comparison. Another agency program, the Health Professions, has as one of its goals the placement of health professionals. A third agency program, the National Health Service Corps, provides a closer comparison in that it also works to place health care providers in key areas by providing a financial incentive directly to the provider. The Nursing Education Loan Repayment and Scholarship Program has a lower per provider unit cost than the NHSC. However, the unit cost is difficult to compare given the variation in provider type and the program is not yet able to show retention of its clinicians in eligible facilities.	Nursing loan debt is on average lower than that of physicians and the program can place more practitioners per Federal dollar than the NHSC. According to the most recent data available, in 2000 the average cost per placement was $77,400 for the Health Professions, $47,900 for the NHSC, and $11,700 for this program. However, the type of professionals supported by the Nursing Education Loan Repayment and Scholarship Program do not compare with the other two programs. According to the National Conference of State Legislatures, most state scholarship and loan repayment programs have not been evaluated, and thus have no evidence of their effectiveness.	0%	
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	No	No comprehensive evaluations have been conducted. An evaluation of the program's impact could be useful to help target resources and make other management and budget decisions.	Until FY 2001, the program was funded at less than $2.3 million and did not use any of these funds to evaluate the program impact at this level. In addition to a comprehensive evaluation, new data to be collected will include the number of applications received, number of awardees, distribution by state, level of education, ethnicity and gender, awards by facility and the number of recipients who default.	25%	0.0
Total Section Score					**100%**	**17%**

Program Assessment Rating Tool (PART)

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: Clear purpose and unambiguous mission specified in Social Security Act: funds appropriated for specific purposes of establishing paternity, locating non-custodial parents, obtaining child and spousal support, and assuring that such assistance is available to all children for whom it is requested. Same purposes echoed in HHS and OCSE strategic plans. Statute also authorizes research and grants for clearly related services to parents, including access & visitation programs.

Evidence: Section(s): 451, 452(j), 458(f), 466; 469B,& 1115 of the Social Security Act (The Act); HHS Strategic Plan, section 7.2; OCSE Strategic Plans issued 1995, 1996, 2000.

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: In 1999, 21.7 million children had parents who lived in households other than theirs; more than 26% of children in these households live in poverty. Child Support Enforcement serves about 18 million of these children, offering a solution to ensure that both parents contribute to a child's well-being. Child Support Enforcement is designed to help low-income and vulnerable families with children become self-sufficient by obtaining support from the children's non-custodial parents.

Evidence: US Census Bureau statistics show that 22 million children have an absent parent; Census shows that income was higher and poverty lower for families that received all of the child support due them; An Urban Institute study (2002) concluded that as a result of welfare reform, single mothers reliance on private sources of income, including child support, has grown and will continue to do so.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: The Child Support Enforcement program neither duplicates nor competes with other federal or non-federal programs. It serves populations un-served by other programs and takes cases that private firms and attorneys often do not handle or only handle for a sizeable fee. The program is designed to take into account the inter-state nature of much of the work by ensuring certain consistencies, while permitting states to customize appropriate aspects of the work (e.g., payment guidelines).

Evidence: Section 451 of the Social Security Act (The Act); United States General Accounting Office. March 2002. Child Support Enforcement: Clear Guidance Would Help Ensure Proper Access to Information and Use of Wage Withholding by Private Firms. GAO-02-349.; IRS Full Collections Study, 1993.

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: The IV-D program is logically designed as a federal/state partnership. Expenditures are shared based on the Federal Financial Participation rates specified in the Act. Funds are targeted to specific purposes and activities in the Act. Because of interstate issues, a federally led system is necessary. No strong evidence suggests that another system would work better than the current design.

Evidence: GAO/HHS-00-48 "Improving State Automated Systems Requires Coordinated Federal Effort", 2000; Section 454(16)(24) Social Security Act; FY2002 OCSE Annual Statistical Report, Tables 1,2,12; FY2004 A19's; IRS Full Collections Study, see Section 1, Question 3; "Welfare Reform Information Technology" 2000; Lewin Group Study. "Child Support Reforms in the United Kingdom and the United States" by Anne Miller, Office of Child Support Enforcement.

Program Assessment Rating Tool (PART)

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: OCSE federal grants help leverage contributions at state and local levels and do not subsidize state or local government activities that would have occurred without the Federal program. Federal funds are targeted so that services will reach intended beneficiaries; collection outcomes are weighted so that states have incentive to work more difficult cases for low-income public assistance and former public assistance cases, not just potentially high-collection child support cases. There is evidence that this is effective, with collection rates increasing at a faster rate for low-income cases. Private attorneys and collection agencies do not generally serve this needier population.

Evidence: CA Closeout Audit; OCSE Certification Guide; Alternative Systems Penalty Chart. Child Support Enforcement: Clear Guidance Would Help Ensure Proper Access to Information and Use of Wage Withholding by Private Firms. GAO-02-349. Program Trends, FY1999 and FY2001.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation: The program has two long-term performance measures: (1) To increase annual child support distributed collections to $30 billion by FY2008, and to $40 billion by FY2013; [Baseline: $15.9 billion, 1999] (2) To increase cost-effectiveness ratio to $4.63 by FY2008, and to $5.00 by FY2013.[Baseline: $3.94, 1999] The cost-effectiveness measure represents dollars of child support collected and distributed for every dollar expended by Federal and state government to run the program; it is a straightforward measure, but it is subtle enough so that a state can get credit for collections on behalf of a resident of another state. Both the cost-effectiveness ratio and the amount of child support distributed in IV-D cases are indicators identified in the "Child Support Enforcement Strategic Plan with Outcome Measures for FY2000-2004."

Evidence: FY2004 President's Budget projects OCSE's total distributed collections to increase to $39.509 billion by FY2013. OCSE's 5 year strategic plan projected cost-effectiveness to increase to $4.35 by FY2004.

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation: OCSE projects doubling of distributed child support collections from FY2002 amount of $20 billion to FY2013 amount of $40 billion, despite diminishing state fiscal resources available and decreasing caseload that leaves harder-to-serve cases remaining. OCSE expects significant rise in cost-effectiveness, despite recent flat or slightly increasing cost-effectiveness rate in recent past, while states were investing substantial funds in building automation systems. The CSPIA, Child Support Enforcement Performance and Incentive Act of 1998, identifies the cost-effectiveness ratio as one of the five measures against which states will be evaluated, in determination of the amount of incentives they will earn for operating an effective child support program. This legislation itself gives the formula for the ratio and sets a level at which states must perform in order to receive an incentive payment for the measure.

Evidence: Table 3: CSPIA Cost-Effectiveness Ratio; Table 4: FY2004 President's Budget Impacts of Child Support Enforcement Legislative Proposals.

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 12%

Explanation: OCSE has annual goals that demonstrate specific kinds of progress toward long-term goals: (a) Increase from the FY1999 baseling the paternity establishment percentage (PEP) among children born out of wedlock. (b) Increase from the FY 1999 baseline the percentage of IV-D cases having support orders. (c) Increase from the FY 1999 baseline the IV-D collection rate for current support. (d) Increase from the FY1999 baseline the percentage of cases with payments received on arrears (unpaid child support debt). (e) Increase from the FY1999 baseline the cost-effectiveness ratio (total dollars collected per $1 expenditure).

Evidence: Report 1: "Child Support Performance Measures and County Characteristics" in "Examining Child Support Arrears in California: The Collectibility Study" Dr. Elaine Sorensen, Urban Institute, March, 2003; GPRA goals, objectives, targets.

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: OCSE has baselines and ambitious targets for its annual measures. Its targets specify upward collection demands despite decreasing caseloads, constraints on state resources appropriated for the programs, and an increasing proportion of more difficult-to-work cases. For example, current analysis demonstrates that 2/3 of arrears (unpaid child support debt) is owed by non-custodial parents who reported earnings of less than $10,000 in the prior year. As a result of enhanced enforcement tools, OCSE reviewed the targets for the GPRA goals, and increased the targets for the percent of paying cases among IV-D arrearage cases to 61 percent in FY03 and 62 percent in FY04.

Evidence: GPRA goals, objectives, targets. See Section II, Question 3. Table 9: Total Certified Arrearage Amount by Income of Debtor Table 10: Total Certified Arrearage Amount By Percent of Total Arrears Owed by Debtors in Various Income Groups

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: OCSE partners who operate the program include state, local and tribal child support enforcement agencies, courts, law enforcement agencies, and other entities operating under cooperative agreements with IV-D agencies. The program includes an incentive funding system and five incentive measures developed through collaboration with all states that mirror long-term and annual program targets.

Evidence: CSE Strategic Plan with Outcome Measures FY2000-2004; DCL-00-76; Sections 452(g) and 458 of the Act; Section 452(a)(4)(C)(I-iii) of Part D of Title IV-D of the Act; 45 CFR 305.32(f); and 305.60. GPRA documentation: Implementation of GPRA at OCSE, February, 1996; Strategic Plan Review Workgroup, 1999; Memorandum on Strategic Plan Review Workgroup, 1999. New Reporting Instrument, DC-98-65. The Appendix to the Child Support Enforcement FY 2002, Preliminary Data Report shows the CSPIA Incentive Measure Formulas

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

2.6 Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need? Answer: YES Question Weight: 12%

Explanation: Independent evaluations have been an integral part of the OCSE process since FY1994. HHS Office of Inspector General has evaluated the program more than 50 times since 1987; GAO has conducted many evaluations, and the Urban Institute, Center for Law and Social Policy, Lewin Group, are some of the noted independent research and policy analysis firms that have evaluated specific aspects of the child support program. In addition, many major research universities in the U.S. have performed research on the program.

Evidence: The Office of Inspector General evaluated the effectiveness of Access & Visitation, and concluded in 2002 that 61% of noncustodial parents increased the percent of current child support they paid after participating in the program; OCSE responded by proposing to increase funding for the Access & Visitation program, more than doubling it over 5 years. In 2002, the U.S. General Accounting Office found that employers were confused by wage withholding orders sent by private collections agencies; OCSE responded by revising the wage-withholding order format to clarify the relationship between the wage-withholding notice and its underlying court order.

2.7 Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget? Answer: YES Question Weight: 12%

Explanation: The OCSE legislative proposals are clearly aimed at making progress on long-term and annual goals and are frequently aimed at removing obstacles to these goals that have been reported by state partners. For example, the FY2004 budget proposals include new legislative authority to seize funds from bank accounts of delinquent child support obligors in direct response to state difficulties making such seizures in interstate cases. The proposal will directly affect performance on two outcome measures, in particular: collections on arrears and cost-effectiveness. Documentation of the projected outcomes can be tracked through budget documents from initial proposals to Administration budget presentations to Congressional Justifications.

Evidence: Child Support Proposals in FY2004 Budget; Congressional Justifications in FY2004 Budget; A-19's FY2004 Budget.

2.8 Has the program taken meaningful steps to correct its strategic planning deficiencies? Answer: YES Question Weight: 12%

Explanation: OCSE has twice updated its Strategic Plan and will do so again during FY2004 for 2005-2009. OCSE volunteered for the PART assessment during 2003 in order to use it as a baseline for this Strategic Plan update. Also, during 2003, OCSE has contracted for a major analysis of the Federal Parent Locator Service to plan the second generation of its major automation system, updating technological, personnel and organizational structure. OCSE uses state self-assessments and other tools to systematically detect important data that were not foreseen in its strategic plan and to adjust management priorities (e.g., investments to deal with large amounts of undistributed collections and regulatory proposals to deal with outdated definitions of acceptable costs for medical insurance coverage in child support orders).

Evidence: Statement of Work for the Planning Contract; Planning Timeline, April 25, 2003;FPLS Technical Assistance Guide (TAG) Release 3.0, Chapter 7;DCL-01-44 National Technical Assistance and Training Needs;Federal Register May 30, 2002 SIP grant announcement; DCL 01-32 1115 grant announcement; DCL -02-07 Alaska's Electronic Modification of Orders (ELMO); Statement of Work for the Interstate Case Reconciliation Project;DCL-02-32 Interstate Caseload Reconciliation Project.

Program ID: 10001054

Program Assessment Rating Tool (PART)

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?**

Answer: YES Question Weight: 11%

Explanation: OCSE collects annual child support performance data from the states and audits the data each year for completeness, accuracy, and reliability. Data are used in various ways to manage the program and improve performance. OCSE uses the data to hold states accountable for meeting specific performance standards. Since 2000, over $800 million have been awarded in incentives to states for meeting data reliability and performance standards, and 26 states have been precluded for at least one year from earning incentives because of their failure to meet data reliability and performance standards. The authorizing statute also specifies a multi-year timetable for penalizing states who do not correct data reliability and performance problems over time. OCSE also set specific performance and cost-effectiveness standards for states automation projects, preventing and/or recovering Federal reimbursement for ineffective projects and requiring specific cost-effectiveness and break-even standards. Performance and data reliability are clearly improving as a result of the fiscal incentives.

Evidence: GAO-02-349, March 2002; Current and proposed OCSE-34A forms and the Wage Withholding Form; Just Use It Matrix.; Automated Income Withholding Matrix; · Sec. 1115-- http://www.acf.dhhs.gov/programs/cse/pol/dcl-02-15.htm; SIP http://www.acf.dhhs.gov/programs/cse/pubs/2002/news/sipp.htm;FIDMhttp://ocse.acf.hhs.gov/necsrspub/training/fidm/index.html; OCSE summary of PRWORA Certification Review Findings (v1.6 March 23, 2001); Sections 409, 452, 454, 458 of the Social Security Act; Current and proposed; UDC Task Order; SIP Grant; Site Reviews; 45 CFR 305.35, 305.60, 308.0-.308.3.

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?**

Answer: YES Question Weight: 11%

Explanation: Data Reliability Audits (DRA's) are performed annually to determine if the incentive measurement data submitted by states are accurate, complete, and reliable. Program partners are also held accountable through the performance and penalty systems. Accountability is also achieved through administrative costs audits. In fiscal year 1998, the OCSE Office of Audit conducted 23 administrative cost audits with recommended disallowances, costs questioned, and cost adjustments in the amount of $59,228,937. OCSE holds States accountable for failure to implement automation to support the program through penalties.

Evidence: Section 452(a)(4)(C)(I-iii) of Part D of Title IV-D of the Social Security Act; 45 CFR 305.32(f); and 305.60; ACF Performance Plan; Dr. Wade Horn's Performance Plan; Commissioner Heller's Performance Plan; CA Closeout Audit - Jan 4, 2001.

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 11%

Explanation: Grant awards are issued quarterly to each state, based on an estimate of need submitted by the IV-D agency. At the end of each quarter, each state submits an expenditure report (Form OCSE-396A), detailing the amount of federal funds expended during the quarter. If the state over-estimated its needs, the excess un-obligated funds are recouped through a reduction in the next award; if the state underestimated its needs, additional federal funds are added to the next award. The way that child support funds are expended prevents the possibility of lapsing unobligated funds; nor is there any incentive to waste money by quickly committing it at the end of the fiscal year. The detailed audit program already described, as well as statutory prohibitions against using Federal funds for local court and other costs, ensure that funds are spent for intended purposes.

Evidence: OCSE Form 396A; Alabama Systems Report

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: YES Question Weight: 11%

Explanation: The program has a specific cost-effectiveness measure that specifies nationally, and for each state, the amount of child support collected for each dollar of administrative program cost. States can get "credit" for support collected for out-of-state residents. State automation projects are also assessed for cost-effectiveness, with specific break-even requirements that must be met to receive Federal financial reimbursement. (The majority of states have reached break-even point ahead of schedule.) States implementation of competitive procurement procedures is reviewed by OCSE, and the OCSE organization has made frequent and cost-effective use of contractors for administrative staffing, automation planning - development - maintenance, research and planning, and training and work group implementation.

Evidence: OCSE has developed a second Cost-Benefit Analysis model, known as the Revenue Stream model, to measure cost effectiveness for statewide child support enforcement systems based on tangible collection and expenditures data. This CBA model utilizes the actual benefits derived from using annual caseload, collections and costs from administrative expenses and APD expenditures as reported by States. The Revenue Stream Model calculator requires states to input baseline data on the projected growth rate for caseload, collections, administration and Advanced Planning Document expenditures, by averaging the growth rate for the three years prior to implementing the automation. The revenue stream program spreadsheet then projects what the normal growth in these categories would be for next 11 years.

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 11%

Explanation: OCSE has aligned itself with agencies sharing common business needs. These include the Department of Education, the Department of Labor, the State Department, and the Internal Revenue Service. OCSE established a close relationship with SSA, recognizing that the two agencies had common business interests crossing departmental boundaries. More specifically, OCSE uses SSA's National Computer Center to house the FPLS. FPLS data have been used in intra-governmental and intergovernmental data sharing initiatives, resulting in savings totaling over $1.4 billion in one year, namely FY2002. Over the past few years OCSE has been the recipient of several awards that acknowledge the quality and effectiveness of this collaboration and coordination. These awards were the result of evaluations that considered the program's impact, effectiveness and other measures of performance. OCSE and Office of Family Assistance have been collaborating and allocating resources, enabling the Child Support Program to better help TANF clients achieve self-sufficiency through approaches focused on technical assistance & program results.

Evidence: Regulation 45 CFR 303.70(e)(3); FY2003 Data Access Fees Summary Sheet; Financial Management System Document;Data sharing statutory provision(s) SSA: 42 U.S.C. 653, (j) (4); DoED 42 U.S.C. 653, (j) (6); 42 U.S.C. 653 (h) (3); tax offset: 42 U.S.C. 664; GAO states the NDNH is an example of an information source that many program administrators cite as being beneficial in making more timely and accurate eligibility determinations. Benefit and Loan Programs: Improved Data Sharing Could Enhance Program Integrity, GAO/HEHS-00-110, Sept 2000. GAO-sponsored symposium on data-sharing opportunities among federal & state agencies. The Challenge of Data Sharing: Results of a GAO-Sponsored Symposium on Benefit and Loan Programs, GAO-01-67, Oct 2000. Excellence.Gov Award CIO Council & Industry Advisory Council; E-Gov 2003 Gov Solutions Center Award Nomination Pioneer Award.

3.6 Does the program use strong financial management practices? Answer: YES Question Weight: 11%

Explanation: A Data Reliability Audit (DRA) has been performed in all 54 states and territories each year since 1999. In FY1998, OCSE's Office of Audit conducted 23 administrative cost audits with recommended dis-allowances, costs questioned, and cost adjustments in the amount of $59,228,937. In 2002, OCSE revamped and implemented an integrated electronic model based in Microsoft Excel that facilitated dynamic tracking on both S&E and program funds and the ability to verify that budget and actual obligations fell within statutory limits. The system can be updated as financial actions are executed to maintain an accurate, detailed status report, available within minutes. Use of this system reveals potential errors before they occur, significantly improving the efficiency of OCSE administration of S&E and program funds. ACF's regional staff scrutinize quarterly financial reports and respond aggressively to any anomalies or significant changes (e.g. recent responses to large changes in undistributed collections). Clifton Gunderson LLC's ACF FY2002 audit was clear of material weakensses.

Evidence: Table 5: Net Undistributed Collections - 4th Quarter, FY2002 Percent Change from 4th Quarter FY2001; Draft-GAO June, 2002, Exit Conference, Department of Health & Human Services: 310423. DHHS, ACF Financial Statements, September 30, 2002 and 2001; ACF Independent Auditors Report 2001 and 2002, Clifton Gunderson, LLC.

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 11%

Explanation: Upon review of its performance, OCSE recognized the need to develop a medical support performance measure in the FY 2005 strategic plan. Currently, we are expanding our efforts with Medicaid and State Health Insurance Agencies (SCHIP). We convened a national Judicial Symposium to bring together for the first time representatives of Medicaid, SCHIP, IV-D agencies, State Chief Justices & Court Administrators. In addition, OCSE is revising the CSE Program Quarterly Report of Collections (OCSE 34A) to separate undistributed collections into two categories: 1) payments that are properly held and will go out on time to known addresses and 2) collections that cannot be distributed without more research.

Evidence: Current and proposed OCSE-34A forms, propsed supplement OCSE34A; Table 6, Joint payee analysis with UDC. Preface to the OCSE FY2002 Preliminary Data Report.

3.BF1 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: YES Question Weight: 11%

Explanation: Child support audits are mandated by Section 452(a)(4)(C)(I-iii) of Part D of Title IV-D of the Social Security Act. 45 CFR 305.60 establishes these requirements in regulation. The mandate is to perform data reliability, financial management, and other audits as deemed necessary by the Secretary, HHS. All audits are conducted in accordance with audit standards (GAO Yellow Book) promulgated by the Comptroller General of the United States. The principal audit performed pursuant to these requirements at this time is the Data Reliability Audit (DRA). A DRA has been performed in all 54 states and territories each year since 1999.

Evidence: Notice of Intent to disapprove state plan for failure to meet automation requirements - 18 States sent NOI for FSA. 9 States sent NOI for PRWORA automation deficiencies; Alternative Systems Penalties - 10 states had Alternative Systems Penalty for FSA, 4 states had Alternative Systems Penalty for PRWORA. $711,711,838 in penalties taken from 1998-2003.

3.BF2 Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner? Answer: YES Question Weight: 11%

Explanation: OCSE collects annual program performance & quarterly financial information from state grantees. This information is compiled and both aggregate and state level data, issued in two reports each year (one preliminary & one final). The preliminary report includes information for the current fiscal year only in the format of tables, charts, and individual state box scores. These box scores show collection, expenditure, paternity, order, caseload, staffing, and cost-effectiveness information for each state and for each region. A comparison is made with state performance on these elements from the prior fiscal year and includes final data for the fiscal year. This report contains tables that show five-year trends for program information for each state. It includes updated versions of charts and box scores. The preliminary and annual reports are mailed to IV-D directors and interested parties and are accessible on the OCSE web site. The preliminary report also includes a non-technical Preface written by the Commissioner that draws public attention to accomplishments and to problem areas.

Evidence: Child Support Enforcement, FY2001 Data Preview Report: http://www.acf.hhs.gov/programs/cse/pubs/2002/reports/datapreview/ Child Support Enforcement, FY2002 Preliminary Data Report: http://www.acf.hhs.gov/programs/cse/pubs/2003/reports/prelim_datareport/

Program Assessment Rating Tool (PART)

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

4.1 Has the program demonstrated adequate progress in achieving its long-term performance goals? Answer: LARGE EXTENT Question Weight: 20%

Explanation: Long-Term Goal I: Increase the amount of distributed collections to $40 billion by 2013. Actual Progress: $20.1 billion distributed collections in FY 2002. $13.4 billion distributed collections in FY 1997. Fifty percent increase over 5 years. Long-Term Goal II: Increase cost-effectiveness ratio to $5 by 2013. Actual Progress: Cost-effectiveness ratio of $4.13 in FY 2002. Fifteen states already have cost-effectiveness ratios exceeding $5 child support collected for every $1 in program cost, and many others are close. The national average cost-effectiveness ratio has been held down over the past few years by the states that still have not built their statewide, automated child support systems. (CA's cost per case is projected to fall from $60.51 to $25.71 per year when system is complete.) OCSE program structure enables it to deal with such impacts by penalizing states which have not achieved performance standards for systems. (CA has already paid $561million in penalties.)

Evidence: Table 7: CSPIA Cost Effectiveness Ratio; Table 8: CSPIA-States forted in ascending order based on FY2002 increase(decrease) in CSPIA ratio over FY2001. Statutory provisions: 42USC653(h)(I)(j)(2), 654(31), 664, & 666(a)(17).

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: LARGE EXTENT Question Weight: 20%

Explanation: For fiscal year 2001, the child support program has met its annual targets for four of its five measures. The paternity establishment measure was the only one not meeting the target. (Final 2002 numbers are undergoing data reliability audit and are not yet available.) The paternity establishment measure was met easily for several years, because states could take credit for paternities established for children of any age and compare the number established to the number of out-of-wedlock births for a single year. Now that the "backlog" has been handled, states are expected to establish paternities for virtually all out-of-wedlock births for any given year, without being able to take credit for many older children.

Evidence: GPRA goals, objectives and targets. See Section II, Question 3.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: LARGE EXTENT Question Weight: 20%

Explanation: The program collects and distributes about $4 in child support for every $1 spent. The cost-effectiveness ratio of distributed collections to administrative costs was 4.13 for FY 2002. 36 of the 54 states and territories showed an increase in the cost-effectiveness ratio in FY 2002 over FY 2001. Average distributed collections per full-time equivalent staff (state & local) have increased every year for the last 5 years.

Evidence: See tables 7 and 8.FY 2001 and FY 2002 annual reports.

Program ID: 10001054

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Effective
100%	100%	100%	80%	

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?

Answer: YES Question Weight: 20%

Explanation: The child support enforcement program compares favorably to other programs such as Temporary Assistance for Needy Families (TANF), Food Stamps, Medicaid, and Workforce Investment Boards. These programs provide services or support to low-income families with the goal of assisting them to become self-sufficient and off of welfare. While the child support program serves the same population of single, low-income parents as TANF, TANF does not assess comparable measures such as data reliability or family income and does not serve non-custodial parents. A GAO report on private collection agencies (PCA's) pointed out that the IV-D caseload in 2001 was 17 million cases; PCA's handled an estimated 30,000 cases; the fee structure and rules for accepting PCA cases prevent them from providing service to most low-income families. Further, PCA's only accept cases with orders already in place, whereas IV-D programs accept all cases. In May 1998, OCSE and HHS/OIG started a nation-wide criminal enforcement project known as Project Save Our Children (PSOC). Currently, PSOC accounts for $27,759,000.00 in criminal restitution.

Evidence: DCL-99-22: Project Save Our Children Task Forces: http://www.acf.hhs.gov/programs/cse/pol/dcl19922.htm GAO, March 2002. "Child Support Enforcement: Clear Guidance Would Help Ensure Proper Access to Information and Use of Wage Withholding by Private Firms." GAO-02-349.

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?

Answer: YES Question Weight: 20%

Explanation: Independent evaluations have been an integral part of the OCSE process since 1994 when OCSE was selected as a pilot GPRA site. The Institute for Research on Poverty, in a study titled, Child Support and Welfare Caseloads, determined that the improvement in child support collections reduced welfare caseloads by 12 to 17 percent. The Urban Institute determined that As welfare reform has taken hold across the country, single mothers reliance on private sources of income, including child support, has grown and will continue to do so. The child support enforcement program, with its expanded enforcement tools, has contributed to this trend.Improving the efficiency and effectiveness of the child support enforcement program will result in greater numbers of single-mother families being able to count on child support, thereby moving more of America's poor families toward self-sufficiency. Without these continued improvements, child support will remain a dream for many poor children.

Evidence: Institute for Research on Poverty. December 2000. Child Support and Welfare Caseloads. Garfinkel, Irwin; Huang, Chien-Chung; Waldfogel, Jane. DPNo. 1218-00. The Urban Institute. March 1999. Child Support Enforcement is Working Better than we Think. Sorensen, Elaine; Ariel Halpern. United States General Accounting Office. February 2002. Child Support Enforcement: Most States Collect Drivers SSN's and Use Them to Enforce Child Support. GAO-02-239. Office of Inspector General, Department of Health and Human Services. April 2000. Paternity Establishment: Administrative and Judicial Methods. OEI-06-98-00050

PART Performance Measurements

Program: Office of Child Support Enforcement
Agency: Department of Health and Human Services
Bureau: Administration of Children & Families

Measure: Percent of paternity establishment among children born out of wedlock

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
1999	96%	106%	
2000	96%	95%	
2001	96.5%	91%	
2002	97%	95%	
2003	98%		

Measure: Percent of IV-D cases having support order

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
1999	74%	60%	
2000	76%	62%	
2001	62%	66%	
2002	64%	70%	
2003	67%		

Measure: Percent of IV-D collection rate for current support

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2000	71%	56%	

PART Performance Measurements

Program: Office of Child Support Enforcement

Agency: Department of Health and Human Services

Bureau: Administration of Children & Families

Measure: Percent of IV-D collection rate for current support

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2001	54%	57%	
2002	55%	58%	
2003	58%		
2004	60%		

Measure: Percent of paying cases among IV-D arrearage cases

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
1999	46%	55%	
2000	46%	57%	
2001	54.5%	59%	
2002	55%	60%	
2003	61%		

Measure: Cost-effectiveness ratio (total dollars collected per $1 of expenditures.)

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2000	5	4.21	
2001	4	4.18	
2002	4.2	4.13	

PART Performance Measurements

Program: Office of Child Support Enforcement

Agency: Department of Health and Human Services

Bureau: Administration of Children & Families

Measure: Cost-effectiveness ratio (total dollars collected per $1 of expenditures.)

Additional Information:

Year	Target	Actual	**Measure Term:**	Annual
2003	4.25			
2004	4.35			

Measure: Annual child support distributed collections

Additional Information:

Year	Target	Actual	**Measure Term:**	Long-term
2002	baseline	$20billion		
2008	$30billion			
2013	$40billion			

Measure: Child Support Performance Incentive Act (CSPIA) cost-effectiveness measure (ratio of distributed child support collections to administrative costs.)

Additional Information:

Year	Target	Actual	**Measure Term:**	Long-term
2004	4.35			
2005	4.42			
2006	4.49			
2007	4.56			
2008	4.63			

Program Assessment Rating Tool (PART)

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The Agency for Healthcare Research and Quality's (AHRQ) reauthorization directs AHRQ to "conduct and support research and build private-public partnerships to: 1) Identify the causes of preventable health care errors and patient injury in health care delivery; 2) Develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and 3) Disseminate such effective strategies throughout the health care industry." In Appropriations Reports, Congress specifies the expected set-aside for AHRQ-funded patient safety (PS) activities. AHRQ has summarized its statutory authority by establishing as its mission to identify, understand and reduce the risk of harm associated with medical errors and health care system-related problems. To achieve this mission, AHRQ's PS research portfolio has four focuses: 1) Identify threats to PS, 2) Identify and evaluate effective PS practices, 3) educate practitioners, disseminate information and implement practices that will enhance PS, and 4) Monitor and evaluate threats to PS.

Evidence: 1) Healthcare Research and Quality Act (P.L. 106-129) - Title IX of the Public Health Service Act (http://www.ahrq.gov/hrqa99.pdf) AHRQ RFAs are available at http://grants.nih.gov/grants/rfa-files/... 2) April 2001 - PS Research Dissemination & Education (/RFA-HS-01-008.html) 3) February 2001 - Improving PS Demos (/RFA-HS-01-003.html) 4) November 2000 - Developmental Centers for Evaluation & Research in PS (/RFA-HS-01-007.html) 5) February 2001 - Clinical Informatics to Promote PS (/RFA-HS-01-006.html) 6) April 2003 - Safe Practices Implementation Challenge Grants (/RFA-HS-03-005.html) 7) December 1999 - Systems Related Best Practices to Improve PS (/RFA-HS-00-007.html)

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The occurrence of medical errors in hospital settings is not a new phenomenon. AHRQ, FDA, CDC, NCHS, CMS, and other Federal agencies funded PS activities prior to the AHRQ-funded study that lead to the November 1999 Institute of Medicine report, To Err is Human. This report concluded that between 44,000-98,000 Americans die each year due to medical errors, the majority of which were identified as systemic problems rather than poor performance by individual providers. The PS Initiative was established in FY 2001 and focuses on reducing the risk of injury and harm associated with medical errors and establishing and emerging IT that improve PS and quality of care. Since the IOM report other studies have estimated the number of errors to be higher and lower than those estimated by the IOM. Reporting is currently not mandatory, hospital charts are sometimes incomplete, and no entity has a system in place to collect uniform data on these errors. An actual number is unknown.

Evidence: 1) To Err is Human, Institute of Medicine 1999 The report noted that more individuals die each year from adverse events in the delivery of health care than from the combined number of deaths from automobile accidents (43,458) and workplace injuries (6,000).

Program Assessment Rating Tool (PART)

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: Duplication exists; however, in its role on the Quality Interagency Coordination (QuIC) TF AHRQ coordinates and in some cases leads the research component of PS activities across government. The QuIC helps avoid duplication/cost inefficiencies and provides a forum for coordinating PS/quality care. AHRQ focuses on how/why medical errors occur; disseminates findings; and creates comprehensive, national solutions to mitigate/eliminate harm in all health care (HC) settings. HHS agencies fund complementary/overlapping activities. FDA focuses on manufacturers mandatory reporting of adverse events involving medication errors, drug/therapeutic biological products and medical devices, and voluntary/confidential reporting of medication errors by HC practitioners and consumers. CDC maintains voluntary reporting of hospital-associated infections in acute care settings and adverse events associated with vaccination. NCHS collects data on avoidable hospitalizations and complications, and adverse events. CMS national network of 53 Quality Improvement Organizations works with consumers, physicians, hospitals, and other caregivers to refine delivery systems to ensure patients receive proper care at the right time, particularly among underserved populations.

Evidence: 1) Patient Safety Reporting Systems and Research in HHS http://www.ahrq.gov/qual/taskforce/hhsrepor.htm 2) Quality Interagency Coordination Task Force http://www.ahrq.gov/qual/quicix.htm Note: Other Federal agencies and the private sector also fund complementary/overlapping activities. Also, DOD and VA are direct care providers that identify where/why errors occur in their respective settings. Private sector projects are consumer/practice/data system-focused rather than comprehensive.

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: The AHRQ PS portfolio is newly funded and research is conducted in stages. Now that best practices and lessons learned are becoming available AHRQ is moving toward taking lessons learned and implementing successful protocols to improve patient safety in their respective settings. AHRQ sees the need for such "hooks". In some, but not all, of its RFAs AHRQ "expects the funded organizations to have or develop a plan for sustaining the reporting system and all its component parts once the grant expires." In addition, it notifies the applicant that "AHRQ, at some point in the future, may begin requesting information essential to an assessment of the effectiveness of Agency research programs. Accordingly, grant recipients...may be contacted after the completion of awards for periodic updates on publications resulting from AHRQ grant awards, and other information helpful in evaluating the impact of sponsored research."

Evidence: AHRQ RFAs are available at http://grants.nih.gov/grants/rfa-files ... 1) February 2001 - Improving PS Demos (/RFA-HS-01-003.html) 2) February 2001 - Clinical Informatics to Promote PS (/RFA-HS-01-006.html) 3) April 2003 - Safe Practices Implementation Challenge Grants (/RFA-HS-03-005.html)

Program Assessment Rating Tool (PART)

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: AHRQ's PS portfolio has research at its foundation. Through a variety of funding mechanisms (e.g. research demonstration and other grants, contracts, interagency agreements, and cooperative agreements) AHRQ makes awards to domestic, public and private non-profit organizations, including professional societies and associations, educational leadership organizations, provider organizations, health care delivery organizations, health plans, State and local governments, and eligible Federal agencies. These groups are most likely to be positioned to implement findings identified in AHRQ-funded research that could help improve patient safety. As a result, these entities research efforts are targeted to the intended patient population or beneficiaries of safer patient care. In addition, applications that are complete and responsive to an RFA are evaluated for scientific and technical merit by an appropriate peer review group convened by AHRQ in accordance with the review criteria stated in the RFA.

Evidence:

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 10%

Explanation: OMB and AHRQ recently developed two long-term goals that link to the mission of the program.

Evidence: 1) FY 2005 GPRA Plan 2) See "Measures" tab for the long-term goals

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 10%

Explanation: When developing these long-term goals, specific attention was paid to highlighting baseline data and ensuring ambitious targets.

Evidence:

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: YES Question Weight: 10%

Explanation: OMB and AHRQ recently developed two annual output goals that demonstrate progress toward achieving the long-term goals for patient safety activities.

Evidence: 1) FY 2005 GPRA Plan 2) See "Measures" tab for the annual goals

2.4 Does the program have baselines and ambitious targets for its annual measures? Answer: YES Question Weight: 10%

Explanation: When developing these annual goals, specific attention was paid to highlighting baseline data and ensuring ambitious targets.

Evidence:

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 10%

Explanation: The long-term and annual program goals themselves are not included in RFAs, contracts, cooperative agreements, or interagency agreements. However, AHRQ attempts to hold all parties accountable by specifying in RFAs a condensed and all encompassing goal, which is to "accelerate the implementation by local health care organizations of evidence based 'safe practices that eliminate identified hazards and/or reduce risk of harm to patients". Project Officers measure progress toward this goal as they perform their annual site visits with each grantee. PS contract goals are negotiated with the contractor as part of their performance-based contract plans. Contractors are required to commit to milestones contributing to those performance goals and file reports by phone weekly, and written monthly and annual reports. If progress is judged as insufficient agreements may be terminated.

Evidence: 1) September 2002 - RAND Contract for Patient Safety Program Evaluation Center Contract 2) September 2001 - WESTAT Patient Safety Research Coordinating Center Contract

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: YES Question Weight: 10%

Explanation: To independently evaluate the impact of the PS Initiative, AHRQ has a separate PS Program Evaluation Center through a multiyear contract with RAND, which began in September 2002. The objective of this contract is to establish a Center that shall 1) develop an implement an overall evaluation plan, 2) develop baseline PS evaluation measures, 3) utilize formative evaluation procedures, monitor progress, and make recommendations for improvement, 4) assess initiative impacts, outcomes, and adopt diffusion using both qualitative and quantitative assessment, and 5) document and prepare evaluation reports indicating results. The first major evaluation report is due from RAND at the end of September 2003, one year from the signing of the contract.

Evidence: September 2002 - RAND Contract for Patient Safety Program Evaluation Center Contract

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 10%

Explanation: AHRQ's OMB budget justification and Congressional justification display the AHRQ budget request. However, when AHRQ submits its budget request to the Department for review, the annual targets are adjusted according to the funding level requested and/or the final funding level passed back from the Department. Budget requests and funding level decisions are not made based on achieving the established long-term and annual performance goals. In addition, AHRQ does not have in place a model/mechanism that allows it to determine per unit cost of service to help in adjusting its budget or program targets accordingly.

Evidence: 1) OMB Budget Justification submitted each Fall 2) Congressional Justification submitted each February with the President's Budget

Program Assessment Rating Tool (PART)

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

2.8 Has the program taken meaningful steps to correct its strategic planning deficiencies? Answer: YES Question Weight: 10%

Explanation: AHRQ has acknowledged the multiple difficulties of tracking budgetary expenditures along with tying these expenditures to actual program performance. AHRQ plans, using budgeted FY 2003 resources, to begin to deploy a reporting module (phase I) to the activity areas allowing them to view and track their own budgets. Phase II will allow the activity areas to interconnect appropriate areas of the AHRQ's planning system with the budget system through a set of common fields, and finally, the GPRA program goals. The ultimate goal of this project will be targeted integration of the existing AHRQ planning database with the budget database system, allowing AHRQ's leadership to easily identify, and flag for action those program areas that are not meeting their GPRA goals.

Evidence:

2.CA1 Has the agency/program conducted a recent, meaningful, credible analysis of alternatives that includes trade-offs between cost, schedule, risk, and performance goals and used the results to guide the resulting activity? Answer: NA Question Weight: 0%

Explanation: "Capital Assets" questions do not apply to AHRQ's Patient Safety research portfolio.

Evidence:

2.RD1 If applicable, does the program assess and compare the potential benefits of efforts within the program to other efforts that have similar goals? Answer: YES Question Weight: 10%

Explanation: AHRQ often reviews the intent of its program relative to the activities funded by other agencies. To this effect, AHRQ often fills the niche by partnering with other agencies to ensure that there is synergy across efforts. AHRQ is partnering with VA in developing the PS Improvement Corps. With DOD, AHRQ is helping to evaluate their training programs. Both efforts will help AHRQ to develop patient safety officers who will know how to work in cooperation with others in the field on this topic. In addition, AHRQ is working with FDA and CDC to bring together their databases such that there is communication across them.

Evidence:

2.RD2 Does the program use a prioritization process to guide budget requests and funding decisions? Answer: YES Question Weight: 10%

Explanation: AHRQ uses for its own internal program management a ten year plan that has as its strategy to evaluate the context of medical errors and input evaluation data in a common report (FY 2001), evaluate the process for collecting and reporting common data (FYs 2002-2003), evaluate the products that exist to improve patient safety (FY 2004), and adopt those methods that have proven successful (FYs 2005-10).

Evidence:

Program Assessment Rating Tool (PART)

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 9%

Explanation: AHRQ is now requiring grantees to report quarterly on their progress and attend annual meetings where they submit progress reports describing their implementation activities, lessons learned, and preliminary findings. AHRQ has taken steps to withhold funding from grantees whose performance is unsatisfactory. Six months after the project was awarded the principal investigator/primary architect abruptly resigned, taking with him key personnel and university collaborators.

Evidence: 1) Work plan tasks and subtasks 2) Grantee progress reports 3) Grantee financial status reports

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 9%

Explanation: AHRQ's strategic plan guides the overall management of the agency. Each Office and Center has an individual strategic plan and annual operating plan. Cost, schedule and performance are part of the performance plans, including Division, Center, and Agency Directors. The annual operating plan identifies those things that contribute to AHRQ achieving its performance goals and internal management goals. These factors are incorporated into each employee's annual performance plan/review. At the end of each year, the Office and Center Directors review accomplishments in relation to the annual operating plans in preparation for drafting the next year's plans. The results of these reviews contribute significantly to Office and Center performance reports. Some managers performance plans also take into consideration their staffs performance in managing program operation. In addition, contracts are performance-based.

Evidence: Program managers performance contract

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: YES Question Weight: 9%

Explanation: All appropriated funds are obligated in accordance with the annual operating plans, formulated for obligation and outlay on a quarterly basis.

Evidence: 1) Estimated obligations by quarter in apportionments for FYs 2001-2003 2) Actual obligations by quarter for FYs 2001-2003

3.4 **Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: YES Question Weight: 9%

Explanation: AHRQ bids out its contracts to organizations with expertise in the area to ensure cost efficiencies and effective use of Federal resources. Contracts are cost plus fixed fee. In addition, AHRQ has managed a growing number of PS grants with minimal increases in staff to support this function; this too has lead to efficiencies. 84 grants were processed in FY 2002 at 5.5 man hours each up from 60 grants and 5.0 man hours each in FY 2001.

Evidence:

Program Assessment Rating Tool (PART)

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 9%

Explanation: AHRQ often reviews the intent of its program relative to the activities funded by other agencies. To this effect, AHRQ often fills the niche by partnering with other agencies so that there is synergy across efforts. AHRQ is partnering with VA in developing the PS Improvement Corps. With DOD, AHRQ is helping them to evaluate their training programs. Both efforts will help AHRQ to develop patient safety officers who will know how to work in cooperation with others in the field. In addition, AHRQ is working with FDA and CDC to bring together their databases to ensure communication across the databases.

Evidence:

3.6 Does the program use strong financial management practices? Answer: NA Question Weight: 0%

Explanation: The Department prepares audited financial statements for its largest components only, AHRQ's financial statements are not audited.

Evidence:

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 9%

Explanation: The Department prepares audited financial statements for its largest components only; therefore AHRQ has not been audited in the past. However, seeing the need for outside assessment of its financial statements, AHRQ engaged Clifton Gunderson LLP for technical support consultation and analysis of certain financial management practices.

Evidence:

3.CA1 Is the program managed by maintaining clearly defined deliverables, capability/performance characteristics, and appropriate, credible cost and schedule goals? Answer: NA Question Weight: 0%

Explanation: "Capital Assets" questions do not apply to AHRQ's Patient Safety research portfolio.

Evidence:

3.CO1 Are grants awarded based on a clear competitive process that includes a qualified assessment of merit? Answer: YES Question Weight: 9%

Explanation: AHRQ announces research grant opportunities through program announcements and requests for applications. Contract opportunities are announced through a similar process. Grant applications are reviewed for scientific and technical merit by a peer review group with appropriate expertise. Funding decisions are based on the quality of the proposed project, availability of funds, and program balance among research areas. Contracts are awarded using a similar process.

Evidence:

Program Assessment Rating Tool (PART)

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

3.CO2 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: YES Question Weight: 9%

Explanation: Every PS awardee provides progress reports to AHRQ Program Officers on a regular basis. This information includes: 1) a brief narrative on what was actually accomplished during the reporting period and a summation of the cost and level of effort expended for each task, 2) preliminary or interim results and conclusions, 3) problems or delays the awardee has experienced in the conduct of performance requirements including what specific action is proposed to alleviate the problems, 4) adjustments that are being implemented to study plans, and 5) planed activities during the next reporting period.

Evidence:

3.CO3 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: YES Question Weight: 15%

Explanation: AHRQ collects performance data, but has a unique method for making this data available to the public. AHRQ has published and physicians provide in doctors offices 20 tips for consumers to help prevent medical errors and steps to safer health care. In addition, many organizations including the 16 demonstration projects, participating in reporting systems establish special PS committees made up of physicians, nurses, pharmacists, and other health care providers to examine medical error reports and identify actions to implement safe procedures and share strategies. The spread of information expands out from these committees. Also, some of the PS best practices identified in an AHRQ-funded report have been identified by JCAHO and incorporated into their guidance for practitioners. Other information regarding morbidity and mortality cases and medical errors.

Evidence: 1) http://www.ahrq.gov/consumer/20tips.htm 2) http://www.ahrq.gov/consumer/20tipkid.htm 3) http://www.ahrq.gov/consumer/5steps.htm 4) http://www.ahrq.gov/consumer/5tipseng/5tip.htm 5) http://www.webmm.ahrq.gov/

3.RD1 **For R&D programs other than competitive grants programs, does the program allocate funds and use management processes that maintain program quality?** Answer: YES Question Weight: 9%

Explanation: AHRQ's grant awards may be the result of investigator-initiated ideas or in response to program announcements, request for applications, or request for proposals, all of which are peer-reviewed. The peer review process takes into consideration previous experience, a definitive plan for the recruitment of diverse populations, and plans to ensure community involvement in the planning and design process. All research grants are awarded for a specified period of time, at the end of which they must re-compete for additional resources.

Evidence:

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: NO Question Weight: 33%

Explanation: Prior to this year, AHRQ has spent much of its time building the foundation. Progress on the long-term goal is expected to become quantifiable as of FY 2005-06.

Evidence: See "Measures" tab for the long-term goals.

Program Assessment Rating Tool (PART)

Program: Patient Safety
Agency: Department of Health and Human Services
Bureau: Agency for Healthcare Research and Quality
Type(s): Research and Development Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
100%	90%	100%	22%	

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: SMALL EXTENT Question Weight: 33%

Explanation: The AHRQ PS Initiative began in FY 2001. Since this time, AHRQ has worked consistently toward achieving its annual output goals of granting awards, establishing the knowledge base, identifying best practices, initiating demonstration projects, and developing a reporting mechanism and data structure through the National Patient Safety network. All of this is the foundation for building up to the long-term national vision of improving patient safety.

Evidence: See "Measures" tab for the annual goals.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: SMALL EXTENT Question Weight: 33%

Explanation: AHRQ has managed a growing number of PS grants with minimal increases in staff to support this function; this too has lead to efficiencies. 84 grants were processed in FY 2002 at x.x man hours each up from 60 grants and x.x man hours each in FY 2001.

Evidence:

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: NA Question Weight: 0%

Explanation: AHRQ is the only Federal agency with a comprehensive purpose of identifying threats to PS; identifying and evaluating effective practices; educating practitioners, disseminating information and implementing practices to enhance PS; and monitoring and evaluating threats to PS. AHRQ seeks to fund demonstration projects and research efforts that can be generalized to provide national level data on possible technologies and health setting protocols that may improve patient safety.

Evidence:

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results? Answer: NA Question Weight: 0%

Explanation: AHRQ's PS portfolio is new and many initial awards are in their final stage of funding. An evaluation of effectiveness could not be completed until these awards are finalized. The first major evaluation report is due from RAND at the end of September 2003.

Evidence:

4.CA1 Were program goals achieved within budgeted costs and established schedules? Answer: NA Question Weight: 0%

Explanation: "Capital Assets" questions do not apply to AHRQ's Patient Safety research portfolio.

Evidence:

PART Performance Measurements

Program: Patient Safety

Agency: Department of Health and Human Services

Bureau: Agency for Healthcare Research and Quality

Measure: Number of medical errors identified while decreasing the number of severe errors occurring

Additional Information: To-date, an accounting of the number of medical errors occurring is unavailable. AHRQ will begin collecting these data to chronicle the state of the problem. Once identified, AHRQ can begin focusing on eliminating severe and preventable errors.

Year	Target	Actual	**Measure Term:** Long-term
2005	Estb baseline		
2010	Medl/ Severe		

Measure: Percent of hospitals reporting on adverse events as standard practice

Additional Information: The overarching goal is by 2010 to increase the number of medical errors identified while decreasing the number of severe errors occurring. This annual goal is intended to be the first step in achieving the overarching program goal.

Year	Target	Actual	**Measure Term:** Annual
2003	Dvlp reprt mech		
2004	Pilot 50 hosp.		
2005	Analyze # & types		

Measure: Number of hospitals that have successfully deployed hospital practices

Additional Information: In FY 2003, AHRQ established a PS Improvement Corp (PSIC) that will help to train five health care organizations or state/local governments to implement evidence-based proven safe practices.

Year	Target	Actual	**Measure Term:** Annual
2003	PSIC/5 implemt		
2004	15 State/Orgs		
2005	+15 State/Orgs		

Measure: Percent increase in the number of hospitals/providers using Computerized Physician Order Entry

Additional Information:

Year	Target	Actual	**Measure Term:** Long-term
2004	Deploy IT		

PART Performance Measurements

Program: Patient Safety

Agency: Department of Health and Human Services

Bureau: Agency for Healthcare Research and Quality

Measure: Percent increase in the number of hospitals/providers using Computerized Physician Order Entry

Additional Information:

Year	Target	Actual
2005	Estb baseline	
2008	+10%/ +50%	

Measure Term: Long-term

OMB Program Assessment Rating Tool (PART)

Block/Formula Grants

Name of Program: Projects for Assistance in Transition from Homelessness

Section I: Program Purpose & Design (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The purpose of Projects for Assistance in Transition from Homelessness (PATH) is to make formula grants to states and territories to provide outreach, mental health and other supportive services to homeless individuals with serious mental illness. Federal funds are also designed to leverage state and local funds at the provider level. The purpose is stated clearly in the authorizing legislation and is commonly shared by interested parties.	Authorized as part of the McKinney homeless legislation of 1990, PATH authorities are in sections 521-535 of the Public Health Services Act. The legislation specifies PATH is a formula grant to states to provide outreach, referrals and services to individuals with serious mental illness who are homeless or at imminent risk. The program is run by the Substance Abuse and Mental Health Services Administration (SAMHSA).	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The program addresses a problem that can be clearly defined, though data on the problem are limited. PATH is designed to support assertive outreach to homeless individuals with serious mental illness who need assistance but are not pursuing mental health treatment and other services on their own. These individuals are widely considered among society's most vulnerable. The problem is specific, however, reliable data on the target population are not available.	National data on the total number of homeless individuals are flawed. A 1996 national survey estimates 20% of 2-3 million homeless individuals have a serious mental illness. There are no valid estimates of people at risk of homelessness. The agency uses an estimate of 600,000 homeless overall on any given night.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	PATH is a formula grant to all 50 states and requires a one to three grantee match. Overall, the program is designed to support outreach efforts for a hard to reach population in order to enroll them in mainstream services, including public housing programs, community mental health treatment systems, and entitlement programs such as Supplemental Security Income (SSI) and Medicaid. The final impact of the program can only be as significant as the foundation of services to which referrals and enrollments can be made. Setting aside the reliance on a much larger set of systems, the program is designed to provide outreach services to homeless individuals with serious mental illness in order to get them engaged in service systems. PATH funds represent a portion of the outreach effort for this population and local agencies blend with other state, local and Federal sources, which complicates efforts to delineate the program's impact in the context of all other factors.	A 1992 report of the Task Force on Homelessness and Severe Mental Illness called for aggressive outreach services for this population beyond an existing SSA demonstration and VA outreach program. There is evidence that in the years prior to the establishment of the program, this population was generally considered out of the reach of treatment and other service systems and specialized outreach efforts were uncommon. PATH contacts over 100,000 homeless individuals with serious mental illness a year, and over half of states exceed the required match. An evaluation found that because PATH funds constitute a portion of the cost of intervening with the target population it is difficult to disaggregate the impact of PATH dollars.	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	No	State and local governments and private foundations invest in outreach efforts for this population and provide funds to the same entities funded by PATH. As referenced in question three, the program succeeds in leveraging funds and a significant reduction in outreach would result from the program's absence, however, there is nothing inherently unique in the Federal contribution. PATH is, however, the only Federal program designed to provide outreach to the general population of persons with serious mental illness who are homeless or at risk of being homeless. Other Federal programs provide services to homeless individuals with mental illness, including the Mental Health Block Grant and HUD's Supportive Housing Program. An interagency 5-year demonstration called ACCESS funded 18 sites in nine states to support outreach to engage homeless persons and also provided a comprehensive range of services, including mental health and substance abuse treatment, job placement, housing, and other services.	A 1999 GAO report cites overlaps among Federal homeless programs, including mental health support, but did not find a Federal program that shares PATH's mission. In a 1996 evaluation of the health centers program, the IG found community health centers provide outreach to homeless individuals, but that clients are often unwilling to receive services. Data on total state and local spending on outreach for this population are not available.	20%	0.0
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The program distributes funds to states through a formula grant and is still relevant to current conditions. The formula is based on urban populations, which is a reasonable proxy for homeless populations and the matching requirement can help prevent supplantation.	There is no evidence that providing support through a competitive grant or other mechanism would be more effective or efficient than PATH's design.	20%	0.2
Total Section Score					**100%**	**80%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II:	**Strategic Planning**	**(Yes, No, N/A)**				
	Questions	**Ans.**	**Explanation**	**Evidence/Data**	**Weighting**	**Weighted Score**
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	PATH has adopted a limited number of long-term outcome goals related to its mission. The long-term goal most focused on the desired end results of the program is the percentage of homeless persons enrolled by the program who receive community mental health services. Because the focus of the program is to support outreach to get homeless people with serious mental illness ready to access mainstream services, this long-term goal looks not at the outcome of treatment, but the receipt of treatment as an outcome of outreach. In order to track the success of contacts, the long-term goals also measure enrollment and case management rates. The program believes enrollment to be a useful measure because it signals the opening of a case record and the initiation of screening for additional services. The program relies on case management as a measure of success because there is little chance that an individual homeless person assigned a case manager will drop out without continued contact. PATH seeks to contribute to the HHS and HUD broad objective to end chronic homelessness.	These long-term goals were adopted as part of the PART review process. The goals will be referenced in the agency's future GPRA plan. The goals include to increase the percentage of enrolled homeless persons with serious mental illness who receive community mental health services; increase the percentage of contacted homeless persons with serious mental illness who are enrolled in services; and increase the percentage of contacted homeless persons with serious mental illness who receive case management services.	17%	0.2
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	PATH has a limited number of valid annual goals that track progress toward achieving the long-term outcome goals of the program. The goals will be referenced in the agency's future GPRA plan.	PATH's key annual goals include: increase the number of persons contacted through outreach; and maintain the percentage of people who are enrolled into services. A third goal is to increase the percentage of participating agencies that offer outreach services.	17%	0.2
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	Program partners support the overall goals of the program and measure and report on their performance as it relates to accomplishing those goals. PATH's direct grantees provide performance data on annual goals using a common software program. The agency also supports biennial meetings, workgroups and calls to discuss program and planning information with PATH grantees.	Grantees input performance data into a database. Data is compiled to report progress on annual goals, identify poor performers, and design technical assistance. Aggregated data are provided in the agency performance reports.	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	PATH is unique among Federal programs in that it targets homeless individuals with serious mental illness, however, it shares goals with many HUD programs and relies on Federal entitlement programs including Medicaid and Social Security. The program shows evidence of meaningful collaboration with Federal partners and of encouraging collaboration at the local level. The program is also working with HUD to improve grant coordination.	The program collaborates with SSA to improve client enrollment in SSI and with the Centers for Medicare & Medicaid Services to identify impediments to use of Medicaid. HHS and HUD have also been meeting on issues around HHS taking on a greater involvement in support of services for homeless populations, such as through joint grant reviews for HUD continuum of care grants. The program has collaborated with HUD, CMS, other parts of SAMHSA, the Administration for Children and Families, and the Health Resources and Services Administration on policy academies to improve homeless services.	17%	0.2
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	By statute, SAMHSA must evaluate PATH every three years to ensure expenditures are consistent with the authorization and to recommend changes in program design or operations. The evaluation is performed by contract and considers program results relative to its annual goals. The evaluation may be strengthened by adding additional client outcomes.	Section 528 of the PATH authorization requires a regular evaluation. The most recent evaluation was conducted by Westat and supported by SAMHSA and HHS' Assistant Secretary for Planning and Evaluation.	17%	0.2
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	Yes	The program can estimate costs of contacts as an output goal, which is directly associated with the program's outcome goals. The program's annual budget display does not meet all standards of alignment. However, the program's ability to attribute cost to output and the connection between that output and the desired outcomes of the program meets the standards of this question. The program budget supports one major grant activity, easing the task of alignment. Budget planning is tied to strategic planning. The program has measured its impact and can also estimate the impact of funding changes on the number of homeless individuals with mental illness contacted by the program. Program management funds are budgeted elsewhere. Annual budget requests could be improved through an increased focus on what is needed to accomplish program goals. The program develops estimates on past experience, and can also make further progress in estimating actual cost.	This assessment is based on the annual budget submission to OMB and the Congress.	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	NA	The deficiency in this section had been program goals. Through this process, the program has adopted new long-term goals that capture intended outcomes of the program, such as the percentage of homeless individuals with serious mental illness contacted by the program who become enrolled in mental health treatment. The program is estimating the likely outcomes of the program based on past performance. Having these measures in place will also further enable the program to integrate budget planning and strategic planning and determine the level of financial resources needed to obtain long-term outcomes.	The program has adopted new long-term goals. The agency is also drafting a blueprint to end homelessness. The agency also reports developing performance based budgeting to strengthen the links between performance and budget. The agency's restructuring plan consolidates budget formulation, planning and Government Performance and Results Act activities within one unit.	0%	
Total Section Score					**100%**	**100%**

Section III: Program Management (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	PATH grantees submit annual data that are used to measure progress toward achieving annual goals. Data are also used to ensure compliance with program legislation and identify technical assistance needs. Performance is also monitored through regularly scheduled and rotating site visits.	Evidence is from their annual reporting form, annual performance reports and evaluations. An example of an action taken in response to performance data is PATH putting in place a training manual for providers in response to low performance in SSI enrollment.	11%	0.1
2	*Are Federal managers and program partners (grantees, sub grantees, contractors, etc.) held accountable for cost, schedule and performance results?*	No	This question considers accountability for performance of program partners and at the Federal level. Federal staff are assigned grantees by region and track performance in meeting annual goals, but are not held accountable for performance results through employee evaluations or other mechanisms. While staff and managers performance is evaluated regularly on tasks and responsibilities associated with the position, the program agency has not identified the managers who are responsible for achieving key program results and established performance standards for those managers. While funds are distributed by formula, the program is highly engaged with grantees and does reserve the right to withhold funds for failing to show progress in objectives. At the local level, grantees do often use performance-based contracting.	The assessment is based on discussions with the agency and grants management documents. Employee evaluations at the agency are independently handled by each of the agency's three centers. The agency reports additional efforts to enhance accountability of Federal managers for program performance.	11%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	The program obligates funds on schedule and monitors use for the intended purpose. States have one year from the beginning of the award period to obligate funds and two years to spend.	The assessment is based on apportionments, PATH funding documents and financial status reports. The agency is also working on establishing waves of grant announcements to improve the distribution of obligations through the fiscal year.	11%	0.1
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	The program can take additional steps to improve administrative efficiency, but does have some incentives and procedures in place. The program operates with a relatively limited number of Federal staff. The program's application and performance data are reported electronically. Federal staff review proposed budgets to identify excessive costs. The program relies on an HHS service clearinghouse known as the Program Support Center for many internal services. The agency is meeting FAIR Act targets and appears to be making progress toward outsourcing additional services. Outsourced activities include accounting, graphics, human resources, and property management.	The assessment is based on discussions with the agency, FAIR Act reports, and the description of services directed to HHS' consolidated Program Support Center.	11%	0.1
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program does not have a financial management system that fully allocates program costs and associates those costs with specific performance measures. The program is unable to cost out resources needed to achieve targets and results. The program does not capture all direct and indirect costs borne by the program agency, including applicable agency overhead, retirement, and other costs budgeted elsewhere. FTE and administrative expenses are not tied to annual program budgets and the program has not developed a procedure for splitting overhead and capital costs between outputs. The program does develop annual budget proposals that include associated FTE costs, or include informational displays in the budget that present the full cost of outputs.	Assessment is based on annual program management budget requests to OMB and Congress.	11%	0.0
6	*Does the program use strong financial management practices?*	Yes	IG audits of the agency's financial management have identified no material internal control weaknesses. The agency's fiscal monitoring of grant awards is conducted through the SAMHSA Grants Information Management System, which tracks awards and obligations, carry over and submission of quarterly reports, application renewals and final reports. The system is used to flag grantee financial management issues for project officers and Federal managers.	The assessment is based on conversations with the agency, audited statements and Office of the Inspector General reports.	11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	The main deficiencies include use of performance data to enhance accountability and the ability to identify changes in performance with changes in funding levels. Most significantly, at the agency level additional steps are underway to increase accountability for program performance at the Federal level.	The agency has begun rolling out performance contracts as part of an overall management reform plan that will set specific, quantitative targets. These contracts are to include outcome elements focused on program goals. The agency's restructuring plan consolidated budget formulation, planning and Government Performance and Results Act activities within one unit.	11%	0.1
8 (B 1.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	The agency and its contractors conduct regularly scheduled site visits to visit every state every five years. Annual applications include detailed information by provider on services funded, clients served and client characteristics.	Site visit protocol, site visit reports, grantee annual reports, guidance for applicants documents and instructions for annual data reporting.	11%	0.1
9 (B 2.)	*Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	PATH annual performance data are summarized in the performance report and made available on the agency web site. New measures will provide additional useful data. Periodic evaluations of the program are posted on the agency's web site. Fact sheets on state performance are also available.	Agency web site (www.samhsa.gov) and state fact sheets.	11%	0.1
Total Section Score					**100%**	**78%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Large Extent	The program has adopted new long-term goals and has baseline data available that show progress toward meeting its long-term outcome goals. The focus of the program is to support outreach efforts for a hard to reach population in order to enroll them in mainstream services. The first measure tracks the program's success enrolling persons who are homeless and have serious mental illness after contact, or the first stage of intervention. Providers find temporary or longer-term shelter for persons contacted and arrange for mental health treatment, housing, case management and other services for enrolled clients. The second measure captures the portion of homeless individuals who receive mental health treatment, a key outcome of the program. The third measure is an efficiency measure of whether the program is able to maintain unit Federal cost of enrolling a homeless person with serious mental illness into services from a baseline of roughly $668 per enrollment. A Yes on this question would require improved efficiency outcomes and progress on treatment in mental health services.	The assessment is based on the agency's GPRA plan, Healthy People 2010 and PATH program data. The program adopted new data check measures last year to eliminate double counting of contacts. Data are collected from program grantees and validated by program contractors. The periodic evaluation may serve as an additional check of data accuracy. The FY 1999 percentage of contacts who receive mental health services is needed. In 2000, the appropriation was $30,883,000 and the number of enrollees was 46,218. In 1999, the appropriation was $26,000,000 and the number of enrollees was 44,881. As described in Section II, the program has taken steps to improve data collection from grantees and control for outliers in reporting the number of persons contacted. The program estimates over time enrollees will be those who are harder to locate and engage.	25%	0.2

Long-Term Goal I:	Increase the percentage of enrolled homeless persons who receive community mental health services. (new measure)
Target:	75% in 2005
Actual Progress achieved toward goal:	61% in 2000
Long-Term Goal II:	Increase the percentage of contacted homeless persons with serious mental illness who are enrolled in services. (new measure)
Target:	47% in 2005
Actual Progress achieved toward goal:	42% in 2000; 36% in 1999
Long-Term Goal III:	Maintain the average Federal cost for enrolling a homeless person with serious mental illness into services. (new measure)
Target:	$668 in 2005
Actual Progress achieved toward goal:	$668 in 2000; $579 in 1999

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program (including program partners) achieve its annual performance goals?*	Yes	The program sets annual targets and is exceeding the targets. The annual goals relate to outcomes measured in the long-term goals.	The data are available in the agency's annual performance plans. As described in Section II, the program has taken steps to improve data collection from grantees and control for outliers in reporting the number of persons contacted. The agency identified data outliers and restated procedures and definitions to correct any inflated numbers. Data indicate progress on the key annual goal related to the percentage of persons contacted who become enrolled to receive services.	25%	0.3

Key Goal I:	Increase the number of persons contacted.
Performance Target:	102,000 in 1999
Actual Performance:	109,000 in 2000; 123,000 in 1999
Key Goal II:	Increase percentage of participating agencies that offer outreach services.
Performance Target:	70% in 1999
Actual Performance:	88% in 2000; 88% in 1999
Key Goal III:	Maintain percentage of persons contacted who become enrolled.
Performance Target:	30% in 1999
Actual Performance:	42% in 2000; 36% in 1999

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Small Extent	The agency is meeting the standards of a Yes for having incentives and procedures to measure and achieve efficiencies and has realized some improved efficiencies at the Federal program level. The agency is taking further steps to improve efficiency through reductions in deputy manager positions and consolidation of smaller offices. Measuring efficiency is complicated by the program's reliance on the greater service systems for the population and the potential for reaching the easier to treat individuals first. The program's long-term goals will now track the percentage of contacts enrolled, managed and treated. These data will provide evidence of changes in program cost effectiveness. In the future, the data may also be combined with annual measures of the total number of persons contacted and annual appropriation totals to get an idea of how efficiently the program is enrolling the target population into services. A Large Extent or Yes would require additional data on improvements in efficiencies and cost effectiveness in achieving program goals in the last year.	Assessment is based on annual performance reports, agency restructuring plans, and discussions with agency managers. The agency's GPRA plan had indicated the number of persons contacted per Federal dollar and percentage contacted who become enrolled have declined over the past three years of available data. However, the program found its FY 1997 data to be unreliable and has improved its data collection efforts through the introduction of new grantee data entry software that detects and rejects the entry of performance information by the grantee that would indicate impossible performance. Program mangers believe that in most cases, such outliers showing highly improbable increases in grantee performance were the result of errors in data entry or a lack of understanding of performance measurement methodology.	25%	0.1
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	NA	Because this program is the only Federal program of its kind as noted in Program Purpose & Design, the question weighting is reduced to zero. However, it is worth noting that other Federal programs do provide services to homeless individuals with mental illness, including Mental Health Block Grant and HUD's Supportive Housing Program. The Block Grant and HUD program have not been evaluated for their ability to reach homeless individuals with mental illness and their performance reports do not track their effectiveness in reaching this population. As noted previously, PATH does have documented evidence of effectiveness for its outreach efforts. However, because of their more broad mandates and lack of specific evaluations, an accurate comparison with these other programs cannot be made at this time. A Large Extent would require additional evidence of improved efficiency at the grantee level.	The assessment is based on annual performance reports, GAO report on homelessness, HHS and HUD performance reports. These reports indicate the program is performing well but does not share a similar purpose and goals with other programs for this question. The Supportive Housing Program provides annual competitive grants to communities for housing and supportive services for the homeless. Similar to PATH, the HUD program can support outreach and case management, but it also supports a longer list of services such as child care, employment assistance and outpatient health services.	0%	

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Large Extent	The most recent final evaluation report of PATH was completed by Westat in late 2000. The evaluation indicates the program is meeting its annual output and outcome goals; responds to resource constraints by targeting the most vulnerable population; and supports the overall service delivery system for this population. The evaluation also indicated states and localities on average provide twice the required one to three match. Evaluation data confirm high levels of enrollment, but data on final entry into treatment, housing or other assistance through PATH funding are not available.	In addition to results related to PATH's annual GPRA measures, key findings include 35% of clients who received PATH funded services were diagnosed with schizophrenia or some other psychotic disorder and an additional 30% were diagnosed with an effective disorder such as major depression or bipolar disorder; outreach is the leading service supported with PATH funds, followed by medical referrals, screening and diagnostic treatment and mental health services; PATH funds are used most frequently to fund salaries of individuals who offer case management services; the leading referrals are for housing, mental health treatment, and substance abuse treatment.	25%	0.2
Total Section Score					**100%**	**67%**

OMB Program Assessment Rating Tool (PART)

Block/Formula Grants

Name of Program: Refugee and Entrant Assistance

Section I: Program Purpose & Design (Yes,No, N/A)						
	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The goal of the refugee program is to assist refugees to attain economic self-sufficiency as soon as possible after arrival.	Authorization in Section 412(a)(1) of the Immigration and Nationality Act	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	All persons admitted as refugees while in the U.S. are eligible for refugee benefits. Federal resettlement assistance to refugees is provided primarily through the State-administered refugee resettlement program. The Office of Refugee Resettlement (ORR) formula grants program assists refugees in obtaining the skills they need for economic self-sufficiency by providing employment services, job training, and English Language Training (ELT).	According to the Refugee Resettlement Program FY 200 Report to Congress, the U.S. admitted 72,489 refugees and Amerasian immigrants in FY 2000. An additional 17,871 Cuban and 1,570 Haitian nationals were admitted as entrants, for a total of 91,960 arrivals. About 63 percent of these refugees spoke no English and required intensive English language and job training.	20%	0.2
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The program is designed for and specifically funded to provide employment and social adjustment services to refugees to assist them in learning about the U.S. culture and labor market and to place refugees in jobs. The Federal government provides 100 percent of the funds to State governments and private, non-profit agencies that are responsible for providing services.	According to ORR's Fall 2000 annual survey of refugees who have been in the U.S. less than five years, about 68 percent of refugees age 16 or over were employed as of September 2000, as compared with about 65 percent for the U.S. population. The total cost of ORR formula grants to States in FY 2001 was $137 million. Social services formula allocations totaled $92 million and targeted assistance allocations totaled $44 million.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	No other program provides formula grants to States to address the needs of refugees for employability services. Without these formula grants, States could not provide the specialized, linguistically and culturally appropriate employment, training and ELT services to newly arrived refugees that prepare them to work in the U.S. and to support themselves as soon as possible after arrival.	ORR provides various resettlement services, cash and medical assistance, for refugees in addition to the employment services being evaluated here. Total ORR funding is around $450 million. The INS inspects and admits refugees, and the State Department provides grants for reception and placement, however, HHS is the only agency that provides resettlement services for refugees.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	This program has achieved significant accomplishments, including: State flexibility in designing programs of assistance and services, family self-sufficiency plans for each case, on-site and desk monitoring, technical assistance, and sufficient funding to allow States to respond quickly to new refugee populations and needs.	The program is centrally administered by ORR and ORR conducts on-site and desk monitoring of States' results. States have direct access to ORR State analysts. ORR published a final rule in March 2000 which gave States flexibility in designing their programs under ORR regulations at 45 CFR Part 400. ORR is now seeing States' responses to the final rule regulatory flexibility in terms of better coordination between cash and employment services.	20%	0.2
Total Section Score					**100%**	**100%**

Section II: Strategic Planning (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	Although ORR currently does not have a 5-year strategic plan or long-term goals for the program, some of ORR's activites are addressed in ACF's five-year plan. More importantly, however, OMB and ORR recently developed ambitious long-term outcome goals that link to the mission of the program.	ORR's newly developed long-term outcome goal that has been revised in the FY2004 GPRA plan is to have an 85 percent entered employment rate (EER). An EER is the ratio of refugees entering employment relative to the number of refugees receiving employment services. States with an EER of less than 50% will be expected to achieve a 5% annual increase in this rate. States with an EER of greater than 50% will be expected to achieve a 3% annual increase in this rate. Average national EERs will be calculated a) for all states, b) for all except the 2 states with the largest caseloads, and c) for each of the two cohorts listed above.	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	In FY 1996, ORR developed specific goals in consultation with the States and these are updated annually in GPRA plans. Improvement along four specific goals have been identified for refugees: entered employment, average wage at placement, employment retention, and entered employment with health benefits available.	Some of ORR's FY 2004 goals shown in the GPRA Annual Performance Plan are: (1) Increase the number of refugees entering employment through ACF-funded refugee employment services by at least 3% annually from FY 1997 actual performance. (2) Increase the number of entered employments with health benefits available as a subset of full-time job placements by 3% annually from FY 1997 actual performance. (3) Increase the number of 90-day job retentions as a subset of all entered employments by at least 3% annually from FY 1997 actual performance.	14%	0.1
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	All States report to ORR on their program performance on a quarterly basis. Quarterly performance is tracked and compared to the Annual Outcome Goal Plan developed by ORR in partnership with each State. Desk and on-site monitoring and the provision of technical assistance are tools used by ORR to assist grantees in improving outcomes.	Quarterly Performance Report (QPR) (ORR-6) (OMB No.0970-0036).	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	Refugee resettlement policies and activities are coordinated with the U.S. Department of State, (DOS) State and community agencies, the Immigration and Naturalization Service, the Social Security Administration, the U.S. Department of Agriculture, Food and Consumer Service, as well as with TANF, Medicaid, and other programs within HHS.	Most of the persons eligible for ORR's refugee program benefits and services are refugees resettled through the Department of State's refugee allocation system under the annual ceiling for refugee admissions established by the President through a consultative process. ORR participates on several DOS interagency workgroups and reviews reception and placement applications. ORR coordinates policy issues with DOJ/INS, SSA, and DOS as appropriate. ORR also conducts annual consultations with its resettlement partners: States, voluntary agencies and other non-profit organizations serving refugees.	14%	0.1
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	No	ORR does not conduct long-term, independent evaluations for this program. However, ORR does complete an Annual Survey of Refugees regarding refugees' education and skills, employment potential, English competence and health. In addition, ORR conducts on-site monitoring of selected States and other grantees to help them achieve improved client employment and self-sufficiency outcomes. ORR also targets States that have large refugee populations and that receive significant refugee program funding for monitoring. In monitoring, ORR assists States and grantees to identify strategies to improve outcomes on ORR performance measures and provides technical assistance on implementing program improvements.	Last HHS Inspector General Report dates back to 1995. No schedule of program evaluation exists.	14%	0.0
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	Due to variability in the number and timing of refugee arrivals in need of employment and social services, the budget cannot be directly aligned with program goals. States can provide employment services to refugees with these funds for up to 5 years after arrival. States' allocations are determined by the number of refugee arrivals per State.		14%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	No	ORR does not have a system for identifying and correcting deficiencies in its strategic planning process. However, through this PART process, ORR has set specific and ambitious long-term goals that were not previously formulated. In addition, ORR is moving towards completing program evaluations focused on improving program performance.	ORR staff participate in a number of workgroups with INS, DoS, and the Refugee Council USA to seek solutions to problems. In addition, ORR plans to hold a series of consultations with State Refugee agencies concerning long-term performance goals. Activities would begin in late winter and/or early spring 2003.	14%	0.0
Total Section Score					**100%**	**57%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section III: Program Management (Yes,No, N/A)						
	Questions	**Ans.**	**Explanation**	**Evidence/Data**	**Weighting**	**Weighted Score**
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	The Quartelry Performance Report (QPR) is the established reporting and data collection instrument for capturing data on States' performance. ORR uses performance data to plan program monitoring. Desk monitoring and tracking of QPR data occur quarterly. Data are validated by periodic on-site monitoring, in which refugee cases are randomly selected and reviewed. Outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages and job retention.	QPR. ORR uses its performance data to target States with low performance for on-site and/or intensive desk monitoring; and provides technical assistance to States with low performance. For example, as a result of ORR monitoring, a sub-recipient of social services in San Diego, CA was terminated as a provider due to poor perfromance and a corrective action plan was implemented for Indiana as a result of monitoring.	11%	0.1
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	Federal accountability is reflected in the Senior Managers' Perfromance Contracts with the Assistant Secretary. Federal Managers identify several discrete goals on which they will be evaluated.	The ORR Director's Performance Contract.	11%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	Form SF-269 is used to report actual expenditures made by the States consistent with the approved State Plans for Refugee Resettlement and in accordance with all applicable statutes and regulations. Financial analysts in ACF staff offices track grantees' draw-downs and liquidations of obligations on a quarterly basis. Grantees respond to single audits and the ORR Director responds to audit findings as the responsible entity.	ORR staff and staff in the ACF Office of Administration examine quarterly expenditure reports. On-site reviews examine financial management systems of grantees and test transactions.	11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	Yes	ORR does have a contract for program monitoring and evaluation of effectiveness, and contract staff assist ORR staff in monitoring programs and validating outcome data. However there are no incentives for States to improve performance. ORR indicates that States voted not to set up incentives or penalties, rather to publish data on each State's annual targets and actual performance, which are in the ORR Annual Report to Congress. The publicity serves as an incentive for improved performance.	ACF Performance Plan. ORR Annual Report to Congress. States are required to provide information to ORR regarding expenditures to achieve outcomes quarterly and annually. ORR uses these data to compute unit costs per placement as a measure of cost effectiveness. In each Annual Report, ORR reports the range of costs per job placement for States and describes how unit costs function as a measure of cost effectiveness. ORR also uses these data to direct its annual goal plan negotiations with States by asking States to hold the unit cost constant, which often results in increased goals for the number of entered employments to be achieved.	11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The allocation formula for social services is set in statute at section 412 (c) (1) (B) of the INA which requires that funds for grants be allocated among the States based on the total number of refugees who arrived in the U.S. not more than 36 months before the beginning of the FY. The allocations for Targeted Assistance formula are based on section 412 (c) (2)(B)(ii) of the INA which requires that 95% of the amount of the grant award is made available to the county or other local entity that qualified for the allocation.		11%	0.0
6	*Does the program use strong financial management practices?*	Yes	The ACF Audited Financial Statements for the past three years have demonstrated that ORR does not have any material weaknesses. ORR staff review and analyze the Quartely Performance Report and SF-269 reports submitted quarterly by State grantees. The issuance of grant awards is contingent upon submission of an Annual Services Plan to ORR. States are also subject to annual single audit requirements. This program is subject to numerous congressional earmarks, which has complicated financial management processes.	1) SF-269 2) ORR Annual Services Plan. 3) FY 1999, 2000, and 2001 ACF Audited Financial Statements.	11%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	ORR does have a system for evaluating the effectiveness of its management through performance contracts, the EPMS system, and the FMFIA requirements, the ACF annual audited financial statement.	FY 2000 Federal Managers Financial Integrity Report	11%	0.1
8 (B 1.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	Grantees are required to file program and financial reports quarterly which describe activities undertaken during the quarter, specifically to accomplish the yearly goals and objectives the State has proposed. Monitoring activities undertaken during the quarter are also reported.	ORR-6, SF-269. monitoring reports, and corrective action plans	11%	0.1
9 (B 2.)	*Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	The program collects unduplicated annual performance data once a year. These data are published in the ORR Annual Report to Congress with State by State perforrmance comparing a State's last year's actual performance on each of ORR's six measures to the current year's performance.	ORR Annual Report to Congress and on ORR website.	11%	0.1
Total Section Score					**100%**	**89%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score

Section IV: Program Results (Yes, Large Extent, Small Extent, No)						
	Questions	**Ans.**	**Explanation**	**Evidence/Data**	**Weighting**	**Weighted Score**
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	No	ORR did not previously have long-term outcome goals set and established in their annual GPRA plan, however through this PART process, they established very aggressive targets.	Revised FY 2004 GPRA Plan	15%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Long-Term Goal I:	85% entered employment rate (EER). States with an EER of less than 50% will be expected to achieve a 5% annual increase in this rate. States with an EER greater than 50% will be expected to achieve a 3% annual increase in this rate. Average national eer's will be calculated a) for all States, b) for all except the 2 States with the largest caseloads, c) and for each of the 2 cohorts listed above. ORR expects to establish performance objectives for each of these categories.				
	Target:	By 2012, grantees will achieve an 85% EER.				
	Actual Progress achieved toward goal:	Long term goals have not been measured as of this date because ORR must consult with the States prior to implementation.				
2	*Does the program (including program partners) achieve its annual performance goals?*	large extent	Annual goals are in place and States strive to achieve these goals. However, achievement of annual goals is contingent upon entering refugee populations (i.e. some populations have more barriers to employment than others).	GPRA Plans; Annual Reports to Congress	15%	0.1
	Key Goal I:	Increase the number of refugees entering employment through ACF-funded refugee employment services by at least 3% annually from FY 1997 actual performance.				
	Performance Target:	FY 02: 59,730; FY01:56,885; FY00: 54,176; FY99: 51,597				
	Actual Performance:	FY 02: N/A; FY01:N/A; FY00: N/A; FY99: 50,208				
	Key Goal II:	Increase the number of entered employments with health benefits available as a subset of full-time job placements by 3% annually from FY 1997 actual performance				
	Performance Target:	FY 02: 32,144; FY01:30,613; FY00: 29,156; FY99: 27,767				
	Actual Performance:	FY 02:N/A; FY01:N/A; FY00: N/A; FY99: 28,425				
	Key Goal III:	Increase the number of 90-day job retentions as a subset of all entered employments by at least 3% annually from FY 1997 actual performance				
	Performance Target:	FY 02: 43,915 FY01:41,824; FY00: 39,833; FY99: 37,936				
	Actual Performance:	FY 02:N/A; FY01:N/A; FY00: N/A; FY99: 36,055				
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	small exten	In annual negotiations with States, ORR strives for increased outcomes and steady or decreasing unit costs per entered employment. Unit costs are tracked and reviewed based on annual performance, however meeting performance targets to reduce unit costs are not part of ORR's annual goals.	FY 2000 Annual Reports; State reports	15%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Yes	There are no other programs with similar purpose and goals. This is the only domestic program funded to meet the employment needs of refugees in a linguistically and culturally appropriate manner. Other mainstream employment programs do not provide services in a way that refugees can understand. However, the costs of providing these services to refugees are not out of line with other employment programs that serve the mainstream caseload.	The Refugee Act of 1980, 45 CFR Part 400 , and policy guidance of the Director, ORR.	35%	0.4
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	N/A	There are no legislative requirements nor are special funds available for this purpose. There are, however, internal assessments in place that reveal that the program is effective and achieving results. Refugee Annual Survey data from FY 1993 to FY 2001 indicate that the refugee "employment to population ratio" (EPR) increased by 169%. The 2001 EPR for refugees is equal to the EPR for the U.S. population.	FY 2000 ORR Annual Report and Annual Survey	20%	0.0
Total Section Score					**100%**	**50%**

Program Assessment Rating Tool (PART)

Program: Resource and Patient Management System
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The program purpose is clear. The Resource and Patient Management System (RPMS) is a distributed electronic information system designed to enhance the ability of Indian Health Service (IHS), Tribal and Urban facilities to provide high quality health care to American Indian/Alaska Native (AI/AN) patients by providing accurate, timely and comprehensive clinical and administrative information to health care providers and program managers at the local, regional and national levels.

Evidence: 25 U.S.C. 1662, Automated Management Information System requires IHS to establish an automated management information system that would include ". . . a financial management system, . . . a patient care information system for each Area served by the Service, . . . a privacy component that protects the privacy of patient information held by, or on behalf of, the Service, and . . . a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service. "

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The multidisciplinary health care providers in IHS, Tribal and Urban facilities require accurate, timely and comprehensive information about the AI/AN patients they serve. Local, area and headquarters managers need access to this information for planning and management. Clinicians and administrators need this information for clinical and health systems research and analysis.

Evidence: RPMS is an integrated system consisting of over 60 software applications that allow for data to be recorded, entered and accessed at each of the various service points. Examples of the patient-based clinical applications include the diabetes case management system, dental data system and immunization tracking system. Examples of the patient-based administrative applications are the patient registration system, third party billing system and medical staff credentials. Examples of the financial and administrative applications are the area data consolidation, area office billing tracking system and IHS contracts information system.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: RPMS is an automated management information system that addresses the unique needs of the diverse set of IHS, Tribal and Urban health care delivery facilities and programs and the AI/AN population. RPMS shares a common technical core with the Department of Veterans Affairs (VA) and includes design features that facilitate integration with private sector products.

Evidence: In its initial design phase, RPMS adopted VA's hospital-based information system, Decentralized Hospitalization Computer Program, as its foundation. Modifications were made in the core programming to meet IHS unique needs. These unique features include: primary focus on outpatient care; inclusion of cultural information such as tribal affiliation and blood quantum; ability to bill third parties; local facility flexibility to implement components of RPMS software without implementing the entire system (e.g. a small outpatient facility would not need the Blood Bank or Admission/Discharge/Transfer software).

Program Assessment Rating Tool (PART)

Program:	Resource and Patient Management System
Agency:	Department of Health and Human Services
Bureau:	Indian Health Service
Type(s):	Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

1.4 **Is the program design free of major flaws that would limit the program's effectiveness or efficiency?** Answer: NO Question Weight: 20%

Explanation: RPMS is not free of major flaws that would limit its effectiveness or efficiency. RPMS cannot provide a valid cost accounting link to health outcomes by specific activity and respective funding sources between its patient-based clinical and administrative applications and financial and administrative applications.

Evidence:

1.5 **Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly?** Answer: YES Question Weight: 20%

Explanation: RPMS is effectively targeted so that resources will reach the intended beneficiaries and address the program's purpose.

Evidence: The IHS Information Resources Management Plan and the IHS Enterprise Architecture show that RPMS is designed around a blend of national, regional and local site level responsibilities to ensure that national program resources are used to maintain economies of scale and uniformity of design when appropriate. Also, as mentioned above, sites have flexibility in which software packages to implement.

2.1 **Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program?** Answer: YES Question Weight: 11%

Explanation: RPMS has a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program.

Evidence: (1)Improve compliance with clinical practice guidelines for five chronic diseases (diabetes, asthma, cardiovascular disease, HIV/AIDS and obesity) through the development and deployment of an electronic health record (EHR) to all IHS, Tribal and Urban sites using RPMS by FY 2008; (2) Derive all national clinical performance measures electronically from RPMS-EHR by FY 2008; and (3) Improve treatment effectiveness in behavioral health services through development and deployment of enhanced automated behavioral health systems to all IHS, Tribal and Urban sites using RPMS by FY 2008.

2.2 **Does the program have ambitious targets and timeframes for its long-term measures?** Answer: YES Question Weight: 11%

Explanation: The program has ambitious targets and timeframes for its long-term measures.

Evidence: By FY 2008, RPMS will: (1) include a case management system for diabetes, asthma, cardovascular disease, HIV/AIDS and obesity and a comprehensive electronic health record; (2) include all 39 clinical GPRA indicators, an automated electronic reporting system and integration into EHR; (3) develop and deploy an integrated behavioral health system.

Program:	Resource and Patient Management System
Agency:	Department of Health and Human Services
Bureau:	Indian Health Service
Type(s):	Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 11%

Explanation: The program has a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals.

Evidence: (1) Develop a comprehensive electronic health record (EHR) with clinical guidelines for five chronic diseases; (2) Expand the automated extraction of GPRA clinical performance measures; and (3) Expand the number of IHS, Tribal and Urban programs that have implemented the use of the Mental Health/Social Services data reporting system.

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 11%

Explanation: The program has baselines and ambitious targets for its annual measures.

Evidence: During FY 2003: (1) Develop and deploy asthma case management software, gather requirements for an HIV/AIDS case management application and preliminary requirements for a cardiovascular disease case management application, continue to enhance diabetes management including enhancement to diabetes case management system and gather requirements for obesity-based indicator; (2) 34 indicators in 12 Areas; complete the collection of baseline data for performance measures begun in FY 2002, implement electronically derived performance measures as their accuracy is proven to be sufficient and distribute semi-automated Laboratory Observation Identifier Nomenclature Codes (LOINC) mapping tool for IHS clinical information system to all IHS, Tribal and Urban sites and achieve full local LOINC mapping at 23 sites; and (3) Assure at least 50 percent of the IHS, Tribal and Urban programs will report minimum agreed-to behavioral health-related data into the national data warehouse by increasing the number of programs utilizing the system by 5 percent over the FY 2002 rate.

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 11%

Explanation: All IHS partners commit to and work toward the annual and/or long-term goals of the program.

Evidence: IHS cannot mandate that Tribal or Urban sites use RPMS. However, 96 percent of Tribal sites (425 0f 445) and 56 percent of Urban sites (19 of 34) use RPMS to submit their performance information. For those Tribal and Urban sites that use a different information system, IHS has a data warehouse to receive and convert this information. To facilitate the commitment of Tribal and Urban partners to the annual and long-term goals of RPMS, IHS has the Information Systems Advisory Committee (ISAC) to identify strategies and long-term goals for RPMS and other IT-related components. The goals of the ISAC guide the development of the Annual Work Plan. The ISAC includes representatives from the National Indian Health Board, Tribal Self-Governance Advisory Committee Board, National Council of Urban Indian Health Board, Council of Chief Medical Officers, and National Council of Clinical Directors.

Program Assessment Rating Tool (PART)

Program: Resource and Patient Management System
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?**

Answer: YES Question Weight: 11%

Explanation: All IHS hospitals and ambulatory facilities are subjected to accreditation surveys by the joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Association for Ambulatory Health Care (AAAHC) on a regular basis. 78 IHS facilities were surveyed in 2000. JCAHO surveyed 81 percent of these. One of the performance areas assessed by JCAHO is Management of Information.

Evidence: The JCAHO scores range from 1 to 5 (substantial, significant, partial, minimal, and noncompliance respectively). The Management of Information function includes five areas which are scored at each facility (Information Management Planning, Patient-Specific Data and Information, Aggregate Data and Information, Knowledge-Based Information and Comparative Data and Information). In 2000, only one IHS facility received a 3 (Patient-Specific Data and Information) in any of the five areas. All other scores were either 1 (substantial compliance) or 2 (significant); the former more prevalent than the latter. In addition, the Institute of Medicine, in its study "Leadership by Example", examining the federal government's quality enhancement processes, noted that "IHS has developed a performance evaluation system to meet the performance measurement requirements of JCAHO's ORYX initiative. . .".

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?**

Answer: NO Question Weight: 11%

Explanation: RPMS and other information technology is funded within Hospitals and Clinics, the single largest activity funded in the IHS budget. Consequently, the performance indicators for RPMS are included in this section of the Congressional Justification. However, the funding level is presented in the aggregate for Hospitals and Clinics. In the Information Technology Infrastructure section of the Congressional Justification, the aggregate funding for Information Technology is presented and the indicators are presented. However, there is no budget linkage to the specific activities of RPMS.

Evidence: IHS FY 2004 Congressional Justification.

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?**

Answer: NO Question Weight: 11%

Explanation: IHS states that its resource needs are presented in a complete and transparent manner in its Capital Asset Plan and Business Case (Exhibit 300 for RPMS). However, this information has not been integrated into its budget justifications.

Evidence: Capital Asset Plan and Business Case, Exhibit 300 for RPMS.

Program Assessment Rating Tool (PART)

Program: Resource and Patient Management System
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

2.CA1 **Has the agency/program conducted a recent, meaningful, credible analysis of alternatives that includes trade-offs between cost, schedule, risk, and performance goals and used the results to guide the resulting activity?**

Answer: YES Question Weight: 11%

Explanation: Alternatives analysis and risk management are an integral and ongoing part of RPMS development. Critical assessments are: Can the desired functionality be obtained within the current technology suite? Is there a commercial product available? If no to these questions, then assess: Can the the desired functionality be built in an integrated environment?

Evidence: One recent example of this process is the IHS Division of Oral Health's request to replace the current RPMS/DDS software with another product. Four alternatives were developed: (1) Do nothing; (2) Improve the current software using existing IHS resources; (3) Replace the current software by partnering with another government agency that is currently developing a dental software solution; and (4) replace the current RPMS/DDS software using the competitive bid process to procure a commercial system. IHS elected to submit a Request for Proposal to ascertain the cost of pursing the fourth alternative in order to conduct a more thorough analysis of the alternatives.

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?**

Answer: YES Question Weight: 14%

Explanation: The IHS Information Technology Support Center (ITSC) regularly collects timely and credible performance information and uses it to manage the program and improve performance.

Evidence: Performance collection tools include: weekly staff reporting, monthly project update meetings and reports, monthly contractor status reports, formal internal quality assurance procedures for software development, formal end-user testing procedures for RPMS software components and after-release bug reporting and enhancement requests, if applicable.

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?**

Answer: YES Question Weight: 14%

Explanation: Federal managers and program partners are held accountable for cost, schedule and performance results.

Evidence: IHS has implemented a Contract Administration Structure that identifies the responsible Federal managers and contracting partner. The Project Officer is responsible for the overall monitoring and performance of the contract and the relationship of the contractor. The Project Officer appoints Task Order Technical Monitors to provide technical assistance and keep the Project Officer apprised of all relevant matters regarding the contractor's technical performance. In 2002, IHS awarded its first performance-based contract. The contract was structured with performance measure standards (developed by the Project Officer and Contracting Officer) and a Quality Assurance Surveillance Plan that sets forth procedures and guidelines that IHS will use in evaluating the technical performance of the contractor. Federal managers and staff annual performance assessments include requirements that they meet objectives by the timelines required.

Program Assessment Rating Tool (PART)

Program:	Resource and Patient Management System
Agency:	Department of Health and Human Services
Bureau:	Indian Health Service
Type(s):	Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: YES Question Weight: 14%

Explanation: Funds for RPMS are obligated in a timely manner and spent for the intended purpose.

Evidence: Virtually all spending for RPMS is for staff or contracts. A schedule for obligations is established with the contractor that aligns with the program plan. Program spending is approved in the Administrative Resource Management System. The system requires the budget officer to sign off that adequate funding exists for the commitment. Additionally, management receives a monthly spending report from the budget officer and a quarterly report from finance. Invoices are reviewed by the Project Officer and Task Order Technical Monitors to validate the contracted work against the items on the purchase order. An automated receiving report is entered to authorize Treasury to issue payment.

3.4 **Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: YES Question Weight: 14%

Explanation: IHS has mechanisms to measure and achieve effectiveness and efficiencies in RPMS development and maintenance. As mentioned above, IHS implemented performance-based contracting principles established by the Department of Health and Human Services (HHS). IHS has also de-layered the contract management structure to empower Project Officers.

Evidence: IHS uses competitive bid process for establishing IT contracts. The responses are evaluated on their technical merits which may, in some cases, outweigh the cost of the lowest bidder.

3.5 **Does the program collaborate and coordinate effectively with related programs?** Answer: YES Question Weight: 14%

Explanation: IHS collaborates and coordinates effectively with related programs within HHS, other Government agencies and non-governmental agencies that share similar goals and objectives.

Evidence: For example, since the mid-1980's IHS has maintained a mutually beneficial sharing agreement with Veterans Health Affairs. In addition, The Government Computer-based Patient Record project is a joint effort of the Departments of Defense and Veterans Affairs and the Indian Health Service. The objective of the project is to enable the electronic exchange of health records among the currently disparate information systems of the participants. Within HHS, IHS collaborates on information technology with the Agency for Health Care Research and Quality, the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration. With respect to non-governmental agencies, IHS has participated in a cooperative effort with the Harvard University affiliated Joslin Diabetes Center in Boston to deploy Joslin's telemedicine modality. In the past year, IHS has sought and obtained data sharing agreements with State agencies for sharing Medicaid eligibility information.

Program Assessment Rating Tool (PART)

Program:	Resource and Patient Management System
Agency:	Department of Health and Human Services
Bureau:	Indian Health Service
Type(s):	Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

3.6 **Does the program use strong financial management practices?** Answer: YES Question Weight: 14%

Explanation: IHS estimates and budgets for RPMS through the information technology capital investment process. The contracts are monitored by IHS Project Officers and Technical Monitors. IHS follows contracting procedures to ensure that payments are made properly for the intended purpose and to minimize erroneous payments.

Evidence: IHS planning and budget documents for RPMS includes plans for staffing and contract expenditures. Project Officers and Technical Monitors scrutinize the contractor's performance through monthly reports, project reviews with contractor management, update meetings and progress demonstrations. The Director of the Information Resources Division and the Executive Officer of the Office of Management Support review monthly commitment registers of all funding obligations against the approved spending plan. An automated procurement system is used to track contract expenditures and deliverables.

3.7 **Has the program taken meaningful steps to address its management deficiencies?** Answer: NA Question Weight: 0%

Explanation: No management deficiencies were identified in this analysis.

Evidence:

3.CA1 **Is the program managed by maintaining clearly defined deliverables, capability/performance characteristics, and appropriate, credible cost and schedule goals?** Answer: YES Question Weight: 14%

Explanation: The program is managed by maintaining clearly defined deliverables, capability/performance characteristics, and appropriate, credible cost and schedule goals.

Evidence: IHS uses competitive bid process for establishing information technology contracts. In 2002, IHS awarded its first performance-based contract to a company providing programming services for the RPMS clinical application, Patient Care Component. The contract was structured with performance measure standards with incentives based on the tasks identified in the Statement of Work, and a Quality Assurance Surveillance Plan for measuring contractor performance and identifying contractor performance incentives.

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: LARGE EXTENT Question Weight: 16%

Explanation: The program has demonstrated adequate progress in achieving two of its three long-term performance goals.

Evidence: The program has demonstrated adequate progress in its long-term performance goals to derive all clinical indicators from RPMS and integrate with EHR and to develop and deploy an automated behavioral health system to all IHS, Tribal and Urban facilities using RPMS. The long-term performance goal to develop a comprehensive electronic health record with clinical guidelines for five chronic diseases is a relatively new measure. The diabetes case management system was developed in 1998, however, there has been no activity on the long-term performance goal since then. The majority of targets for this performance goal are scheduled to be achieved between 2003-2008.

Program: Resource and Patient Management System
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: LARGE EXTENT Question Weight: 16%

Explanation: The program has demonstrated adequate progress in achieving two of its three annual performance goals.

Evidence: The program has demonstrated adequate progress in its annual performance goals to expand the automated extraction of GPRA clinical performance measures and to expand the use of the behavioral health data reporting system. The annual performance goal to develop a comprehensive electronic health record with clinical guidelines for five chronic diseases is a relatively new measure. The diabetes case management system was developed in 1998, however, there has been no activity on this performance measure since then. The majority of targets for this performance goal are scheduled to be achieved between 2003-2008.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: YES Question Weight: 16%

Explanation: The program has demonstrated improved efficiencies or cost effectiveness in achieving program goals each year. The number of modules/packages released has increased with nominal increases in the information technology budget. The increase in the number of modules/packages released can partly be attributed to improved requirements gathering. Additionally IHS has begun to develop products that can be reused between projects. For example, the Human Factors Interface works for the Behavioral Health Graphical User Interface being applied to the Electronic Health Record project with minimum rework.

Evidence: In 2000 IHS released 62 applications at a cost of $6.63 million; in 2001, IHS released 71 applications at a cost of $5.27 million; in 2002, IHS released 72 applications at a cost of $4.05 million.

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: YES Question Weight: 16%

Explanation: RPMS compares favorably to other programs within the federal sector. RPMS includes the same functionality as the Departments of Defense and Veterans Affairs health information systems with additional functionalities such as a life long medical record and population health query ability on demand. RPMS is also able to meet the majority of the minimum functional requirements, and some of the optional functional requirements for clinical practice management information systems used in community and migrant health centers.

Evidence: The Bureau of Primary Health Care Clinical Practice Management Information Systems Functional Requirements provides guidance on minimum and optional requirements for nine categories: Patient Scheduling; Patient Registration; Medical/Dental Data; Patient Follow-Up Monitoring/Tracking; Billing; Accounts Receivable; Management Support; Systems Management; and Managed Care. There are a number of commercial health information software packages, however none provide the functionality at the resource level expended on RPMS.

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results? Answer: YES Question Weight: 16%

Explanation: As mentioned above, RPMS is evaluated on a regular basis through JCAHO facility reviews. IHS facilities consistently score high on its Management of Information reviews.

Evidence: In addition to the JCAHO reviews, IHS is currently pursuing an agreement with AHRQ to facilitate evaluation of RPMS and, specifically, the EHR project. The agreement with AHRQ will also include evaluation of future clinical IT projects.

Program ID: 10001058

Program Assessment Rating Tool (PART)

Program: Resource and Patient Management System
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Capital Assets and Service Acquisitio

Section Scores				Overall Rating
1	2	3	4	Effective
80%	78%	100%	89%	

4.CA1 **Were program goals achieved within budgeted costs and established schedules?** Answer: YES Question Weight: 16%

Explanation: The program goals were achieved within budgeted costs and established schedules.

Evidence: The program has gained efficiencies in the production of RPMS applications due to improved requirements gathering and multiple use. The program has demonstrated progress in achieving two of its three performance goals while achieving economic efficiencies and increased production of applications. As mentioned above, there is no demonstrated performance on one of the measures because the majority of targets are schedule to be performed between 2003 and 2008.

Program ID: 10001058

PART Performance Measurements

Program: Resource and Patient Management System

Agency: Department of Health and Human Services

Bureau: Indian Health Service

Measure: Derive all clinical indicators from RPMS and integrate with EHR: Targets: FY 2000: 23 indicators/1 Area; FY 2002: 18 indicators/10 Areas; FY 2003: 34 indicators/12 Areas; FY 2004: 37 indicators/12 Areas; FY 2008: 39 indicators/integrate EHR

Additional Information: Derive all clinical GPRA indicators from RPMS, integrate the application with EHR and deploy an automated electronic reporting system to all 12 IHS Areas.

Year	Target	Actual	**Measure Term:** Long-term
2000	23/1	23/1	
2002	18/10	18/10	
2003	34/12		
2004	37/12		
2008	39/EHR		

Measure: Develop and deploy automated behavioral health system

Additional Information: Improve treatment effectiveness in behavioral health services through development and deployment of enhanced automated behavioral health systems to all IHS, Tribal and Urban sites using RPMS.

Year	Target	Actual	**Measure Term:** Long-term
2008	592		

Measure: Develop comprehensive electronic health record (EHR) with clinical guidelines for five chronic diseases: *Target: FY 2003: Prototype EHR/Asthma

Additional Information: Improve compliance with clinical guidelines for five chronic diseases (diabetes, asthma, cardiovascular disease, HIV/AIDS and obesity) through the development and deployment of an EHR to all IHS, Tribal and Urban sites using RPMS. The Diabetes case management system was developed in 1998.

Year	Target	Actual	**Measure Term:** Annual
2003	*		

Measure: Expand the automated extraction of GPRA clinical performance measures: Target: FY 2000: 23 indicators/1 Area; FY 2002: 18 indicators/10 Areas; FY 2003: 34 indicators/12 Areas; FY 2004: 37 indicators/12 Areas

Additional Information: Derive all clinical GPRA indicators from RPMS, integrate the application with EHR and deploy an automated electronic reporting system for all 12 IHS Areas.

Year	Target	Actual	**Measure Term:** Annual
2000	23/1	23/1	

PART Performance Measurements

Program: Resource and Patient Management System

Agency: Department of Health and Human Services

Bureau: Indian Health Service

Measure: Expand the automated extraction of GPRA clinical performance measures: Target: FY 2000: 23 indicators/1 Area; FY 2002: 18 indicators/10 Areas; FY 2003: 34 indicators/12 Areas; FY 2004: 37 indicators/12 Areas

Additional Information: Derive all clinical GPRA indicators from RPMS, integrate the application with EHR and deploy an automated electronic reporting system for all 12 IHS Areas.

Year	Target	Actual
2002	18/10	18/10
2003	34/12	
2004	37/12	

Measure Term: Annual

Measure: Percent increase in IHS, Tribal and Urban programs that use the national behavioral health data reporting system

Additional Information: Increase the percentage of IHS, Tribal and Urban programs that have implemented the use of the Mental Health/Social Services data reporting system.

Year	Target	Actual
2000	10%	25%
2001	10%	12%
2002	5%	5%
2003	5%	
2004	5%	

Measure Term: Annual

Program Assessment Rating Tool (PART)

Program: Runaway and Homeless Youth
Agency: Department of Health and Human Services
Bureau: Family and Youth Services Bureau (FYSB)
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	38%	90%	0%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The purpose of the Runaway and Homeless Youth Programs is to develop an effective system of care for youth who have become homeless or who leave and remain away from home without parental permissionto include preventive services (RHY Street Outreach Program), emergency shelter services (RHY Basic Centers), and extended residential shelter (RHY Transitional Living Program)outside the law enforcement, juvenile justice, child welfare and mental health systems.

Evidence: Evidence: Authorizing Legislation P.L. 106-71, Sec. 302, Sec. 311(a)(1), Sec. 311(a)(2), Sec. 321, and Sec. 322(a)

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The program addresses the crisis needs of runaway and homeless youth by providing youth with emergency shelter, food, clothing, counseling and referrals for health care. The U.S. Department of Justice estimates that nearly 1.7 million young people ran away or were thrown out of their homes in 1999. Of those youth, an estimated 1.2 million (71%) could have been endangered by factors such as substance dependency, use of hard drugs, sexual or physical abuse, or presence in a place where criminal activity was occurring. In 2002, data from the Runaway and Homeless Youth Management Information System (RHYMIS) indicated that more than 685,000 young people received services through the Runaway and Homeless Youth programs.

Evidence: 1. Hammer, H., Finkelhor, D., and Sedlak, A. October, 2002. Runaway/Thrownaway Children: National Estimates and Characteristics. From National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children, U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. 2. RHYMIS data.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: RHY programs are not redundant or duplicative of any other Federal, state, local or private effort because, unlike other efforts, RHY programs are focused on the crisis needs of runaway and homeless youth (under age 18 for Basic Centers and Street Outreach, and from ages 16-21 for TLP) that are outside the juvenile/criminal justice and child welfare systems. Programs offering roughly similar services exist, but target very different populations that require separate care. For example, HUD programs for the chronically homeless serve adults and address the basic needs of food and shelter. The Foster Care Independent Living Program serves child welfare system youths that are aging out of Foster Care (ages 18-21). Shelters for victims of domestic violence serve battered women and families.

Evidence: Evidence: HUD statement of Program Goals and Objectives. The Foster Care Independent Living program legislation (Section 470 and 477 of the Social Security Act). The Domestic Violence Battered Women's Program legislation (Section 310 and 311(g) of the Family Violence Prevention and Services Act).

Program ID: 10001064

Program Assessment Rating Tool (PART)

Program: Runaway and Homeless Youth
Agency: Department of Health and Human Services
Bureau: Family and Youth Services Bureau (FYSB)
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	38%	90%	0%	

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: The program awards grants on a competitive basis. There is no evidence to suggest that an alternative mechanism would be more efficient or effective.

Evidence: The FY 02 appropriation of $92.5 million in discretionary funds provided for a total amount of 619 runaway and homeless youth grants. Under a Block Grant structure, with a required 5% administrative fee, the total discretionary funding available for grant awards would be $87.9 million. The $4.6 million in administrative costs would correspond to a reduction of 31 grants (at an average grant award of $149,435). 424A Budget Justification with match.

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: First, the funding available to each State for RHY Basic Centers is determined by a formula based on census data of the population of youth under age 18 in each State. Since the shelters provided by Basic Centers must be prepared to respond to the immediate needs of youth in their community on demand, this is a very effective way to predict such demand. Second, all RHY grants are awarded competitively, and are able to ensure effective targeting of intended beneficiaries by requiring in the evaluation criteria for each grant that the "Applicant must state the need for assistance by describing the conditions of youth and families in the area to be served and the estimated number and characteristics of runaway and homeless youth and their families." Third, to ensure that resources effectively target youth within the communities, RHY grantees provide street-based outreach through the Street Outreach Program. Finally, Federal Staff in the regional offices monitor RHY services to improve overall program quality and ensure the attainment of measurable results.

Evidence: Evidence: FY 02 State Funding Based on Census Population Data. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Administration for Children and Families (ACF), [Program Announcement No. ACF/ACYF/RHYP 2003-01]

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: NO Question Weight: 12%

Explanation: Though one long term measure is under development, it will likely not be ready to be included in the FY05 GPRA plan. This measure will focus on the number of youth who remain employed or full time students six to twelve months after successfully completing the transitional living program. One or two additional long term measures should be developed, including an efficiency measure.

Evidence: Under development. FYSB plans to increase the number of youths who remain employed or full time students 6 to 12 months after completing the program. The purpose of the goal is to help youth successfully transition to adulthood and increase economic independence and self sufficiency.

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: NO Question Weight: 12%

Explanation: The developmental targets include increasing by 8 percentage points the percent of youth who remain employed or are full time students after successfully completing the transitional living program by 2009. Forty-eight percent of youth completed the TLP in FY 02. FYSB would like to contact these youths to see if they remain economically independent after successfully completing the TLP.

Evidence: The long-term targets and timeframes are under development.

Program: Runaway and Homeless Youth
Agency: Department of Health and Human Services
Bureau: Family and Youth Services Bureau (FYSB)
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	38%	90%	0%	

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: YES Question Weight: 12%

Explanation: RHY programs have 4 discrete, quantifiable, and measurable annual performance measures (an efficiency measure is under development). Since the program received a No for Question 2.1, it is necessary to note that the annual performance measures contribute directly to the purpose of the program (as defined in 1.1) as well as the desired long-term general outcomes espoused by the RHY Positive Youth Development Approach (PYDA). The PYDA is rooted in the notion that youth who are provided safe settings, appropriate structure, supportive relationships, opportunities to belong, positive social norms, civic engagement, skills, and the integration of family, school, and community are more likely to successfully reunite with their family and navigate toward independence. For example, the Transitional Living Program's annual performance measure is increasing the number of youth who are employed or are full time students after completing TLP. Attainment of the annual goal ensures that youth are provided tools, training, and experiences to feel prepared for life, consistent with the PYDA.

Evidence: Evidence is the Agency's 2004 GPRA plan and FY 2002 RHYMIS data. Positive Youth Development studies: NCFY publications (Reconnecting Youth & Community, The Exchange, State Collaboration Demonstration Projects); Academy for Educational Development and National Training Institute for Community Youth Work, 2000 Best Initiative (www.aed.org), American Youth Policy Forum, Things That Do Make A Difference for Youth: A Compendium of Evaluations of Youth Programs and Practices, 1999,2000,2001, Community Programs to Promote Youth Development, National Research Council, Institute of Medicine, 2002.

2.4 Does the program have baselines and ambitious targets for its annual measures? Answer: NO Question Weight: 12%

Explanation: Only one of the four annual measures has clearly ambitious targets: increasing from 81% in 2002 to 86% in 2003 the percentage of youth living in safe and appropriate settings after exiting the runaway and homeless youth programs. However, since each of the remaining measures seek to increase annual performance by just a single percentage point, it is not clear that the annual targets are sufficiently ambitious.

Evidence: FY 02 RHYMIS data and FY 04 GPRA.

2.5 Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program? Answer: YES Question Weight: 12%

Explanation: Program partners support the overall goals of the program as indicated by mandatory reports that are submitted by contractors and grantees, relating to the accomplishment of program goals. Grantees are required by contract to submit performance data through RHYMIS. The data is collected through a contractor, and the logistical contract is used to support the peer monitoring program which is designed to enhance grantees ability to perform within the established goals and measures. The national clearinghouse contract serves as a central information point for professionals and agencies involved in the development and implementation of services to young people and their families. The program also supports annual regional meetings, workgroups and monthly calls with Federal Regional Staff to discuss program goals and objectives. FYSB conducts annual grantee meetings with Training and Technical Assistance and State Collaboration grantees.

Evidence: Evidence: Requirements are included in Program Announcement (RHYMIS, Research or Evaluation, Annual Report and Other Reports (Financial), Semi-annual reports by grantees and monthly report by contractor. Annual Meetings.

Program Assessment Rating Tool (PART)

Program: Runaway and Homeless Youth
Agency: Department of Health and Human Services
Bureau: Family and Youth Services Bureau (FYSB)
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	38%	90%	0%	

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?**

Answer: NO Question Weight: 12%

Explanation: There is no independent evaluation conducted on a regular basis.

Evidence: N/A

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?**

Answer: NO Question Weight: 12%

Explanation: RHY annual budget requests, as do those of most all ACF programs, include a budget linkage table that displays outputs and outcomes associated with the aggregate program budget authority. This table does not provide a presentation that makes clear the impact of funding, policy, or legislative decisions on expected performance nor does it explain why the requested performance/resource mix is appropriate.

Evidence: Annual budget submission to OMB, Congressional Justification, and FY 04 GPRA plan.

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?**

Answer: YES Question Weight: 12%

Explanation: The program has taken meaningful steps to correct strategic planning deficiencies by developing a limited number of both long-term and annual performance goals that demonstrate progress towards achieving FYSB's long term outcomes. Changes include establishing outcome measures to track transitional living program youths 6 months after they exit the program to see if they remain economically independent.

Evidence: Under development: FY 2005 GPRA

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?**

Answer: YES Question Weight: 10%

Explanation: Performance information is collected from grantees through a variety of vehicles: semi-annual RHYMIS data submissions and annual reports, ongoing grantee monitoring, and monthly grantee progress reports. This information is used to adjust program priorities, allocate resources and monitor the performance activities carried out by grantees. For example, when monitoring determines that a grantee is performing at an unacceptable level, corrective action is taken. In some instances a successor grant is made to replace a grantee that is not performing to standards. Additionally, RHYMIS data is used by FYSB to accurately reflect the number of youths receiving services from the runaway and homeless youth programs. Finally, grantees are required to submit semi-annual reports to their federal project officers for the purposes of identifying successes and challenges of administering the grant. The progress reports along with the legislatively required monitoring of programs identify the training and technical assistance needs of grantees in providing services to the RHY population.

Evidence: Evidence: Existing RHYMIS Data, Semi-Annual Progress Reports and Monitoring Reports with Corrective Action, Successor Grant Policy.

Program Assessment Rating Tool (PART)

Program: Runaway and Homeless Youth
Agency: Department of Health and Human Services
Bureau: Family and Youth Services Bureau (FYSB)
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	38%	90%	0%	

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?**

Answer: YES Question Weight: 10%

Explanation: FYSB Associate Commissioner and other ACF managers are held accountable for their performance through their Employee Performance contract for cost, schedule, and performance results, as required by GPRA. Federal Project Officers have to be certified by the Agency and they are held accountable for cost, schedule, and performance of contracts and grants. Grantees submit semi-annual SF-269 (Financial Status Report) detailing expenditures for a budget period. The SF-269 is reviewed by the project and grants office for appropriateness of use of funds. Contractors are required to submit monthly invoices of services provided under the contract. These invoices are carefully examined by FYSB program staff for the purpose of assuring that expenditures are in line with the purpose of the contract. Program Support Contract Officers also review the invoices for appropriateness of funds. Staff and managers are held accountable for their oversight of grants and contracts through their annual performance plan.

Evidence: Evidence: FYSB's Associate Commissioner's EPMS plans, Grantees semi-annual progress reports, Contractor's Monthly invoices and progress reports.

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?**

Answer: YES Question Weight: 10%

Explanation: The RHY program funds are obligated on schedule and are monitored for intended purposes. A budget narrative is required as part of the funding requirements for all grantees. Prior approval of budget revisions is required in accordance with grants management policy. Grantee funds are obligated through the GATES system and monitored through the semi annual SF-269 financial status report for a project period. Award recipients typically spend awards during the single fiscal year. FYSB grantees have limited amount of unobligated funds. However, when it's necessary to carryover funds, a carryover request has to be approved and funds can only be used for the purpose of completing unfinished prior approved projects. Federal managers review expenditures for contracts on a monthly basis and approve or disapprove reimbursement items.

Evidence: Evidence: SF-269(Financial Status Report), GATES budgetary negotiation sheet.

3.4 **Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?**

Answer: NO Question Weight: 10%

Explanation: While the program does have procedures in place to achieve efficiencies and cost effectiveness, there are no procedures in place by which to measure such efficiencies. For example, the program contracts out evaluation, technical assistance, public education, logistics and RHYMIS. Federal staff review contractor proposed budgets to identify excessive and inappropriate costs prior to award. Each contract statement of work requires performance plans that include efficiency measures and targets relating to specific deliverables. However, there are no existing efficiency measures to capture the results of such efficiency gains included in the GPRA plan.

Evidence: Evidence: Government Cost Estimates for contracts, Monthly progress and financial expenditure reports. State Collaboration Project Evaluation.

Program Assessment Rating Tool (PART)

Program: Runaway and Homeless Youth
Agency: Department of Health and Human Services
Bureau: Family and Youth Services Bureau (FYSB)
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	38%	90%	0%	

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 10%

Explanation: 1) The FYSB collaborates with ACF's Office of Community Services and Head Start, Housing and Urban Development (HUD), U.S. Dept of Agriculture, Defense, Education, Justice, Labor, Transportation, and the Corporation for National and Community Service to sponsor the National Youth Summit; 2) FYSB's Positive Youth Development State and Local Collaboration Demonstration Project focuses on establishing partnerships and collaborative efforts at the Federal and State-level agencies to improve conditions of runaway and homeless youth and other youth within the community; 3) FYSB is part of the Dept. of Justice Federal Task Force for Missing and Exploited children; 4) FYSB collaborates and coordinates with the ACF's Children's Bureau for it's National Pathway to Adulthood Conference which brings transitional living and independent living program together; 5) Regional Training and Technical Assistance Providers work with grantees to build capacity in the community; and 6) FYSB is participating in the White House Task Force for Disadvantaged Youth.

Evidence: 1) The collaboration of Community Services, Head Start, HUD, Education, et al, helped sponsor the National Youth Summit, which brought together leading policy makers and practitioners to explore how to further the field of "positive youth development." 2) FYSB's five year State Collaboration Demonstration Projects focused on strengthening collaborative efforts of 13 States individual needs relative to positive youth development. 3) N/A. 4) N/A. 5) FYSB 10 training and technical assistance grantees provide youth related services and positive youth development to all RHY programs. FYSB training and technical assistance efforts have resulted in a Department wide cross cutting youth initiative.

3.6 Does the program use strong financial management practices? Answer: YES Question Weight: 10%

Explanation: Office of Inspector General (OIG) financial management audits of the FYSB programs have identified no material internal control weaknesses. The agency's fiscal monitoring of grant awards is conducted through the Grants Management Staff, which tracks awards and obligations. The Federal Project Officer reviews and approves quarterly reports, application renewals and final reports. Also, in addition to the semi-annual program reports, FYSB's on-site monitoring system requires program and fiscal reviews by grantees every three years or on an as needed basis.

Evidence: There is no evidence of any material internal control weaknesses as a result of audited statements and OIG reports. Evidence is OIG Reports.

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 10%

Explanation: The FYSB addresses management deficiencies through the use of its onsight monitoring system. RHY program staff and peer monitors are able to identify program management deficiencies where they exist. When program management deficiencies are discovered the RHY program staff develops a plan for corrective action and delivers appropriate training and technical assistance to correct the deficiency. If deficiencies are not met in a timely manner (as established by the grants management office), steps are taken to cease funding for programs that are out of compliance with legislation/regulations.

Evidence: Evidence is Monitoring Report with Deficiencies and Corrective Actions.

Program ID: 10001064

Program Assessment Rating Tool (PART)

Program: Runaway and Homeless Youth
Agency: Department of Health and Human Services
Bureau: Family and Youth Services Bureau (FYSB)
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Results Not Demonstrated
100%	38%	90%	0%	

3.CO1 **Are grants awarded based on a clear competitive process that includes a qualified assessment of merit?** Answer: YES Question Weight: 10%

Explanation: Grants review is designed to select the best programs for funding (out of a competitive field of 300 applicants in FY 02). Reviewers and panel chairpersons are carefully chosen by FYSB for their expertise in the field, as well as their ability to assess both critically and objectively the quality of a proposed project. Because they are fundamental to the process, application reviewers are only screened and selected by Federal staff. Applications for this program are peer reviewed based on clear criteria, and awards are made based on merit as judged through the peer review process. A panel consists of a chair person and 3-4 reviewers. Final applications are reviewed and approved by Federal subject area managers and project area managers as an assurance that all the federal guidelines are met in accordance with written criteria.

Evidence: In FY 02 there were no Congressional earmarks to limit the distribution of funds based on criteria other than the most qualified applicant. 10 Regional Training and Technical Assistance Providers provide outreach to help new grantees succeed. Turnover rate varies between the three programs. It is smaller in the BCP because the competition pool is limited to interested applicants from within the State. The SOP and TLP turnover rate is higher because competition occurs at a national level. Assessment of best qualified applicants is based on published grant review procedures. The Grant Review Handbook clearly delineates the structure of the process, identifies the responsibilities of the participants, and generally assists reviewers in making every review accurate and impartial. Funding announcements have to go through a clearance process before publication in the Federal Register. Awards are based on the score generated by the panel in accordance with the strengths and weaknesses of the application. Applications with the highest score are those recommended for funding.

3.CO2 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: YES Question Weight: 10%

Explanation: Federal staff serving as project officers receive data on grantees activity through semi-annual progress reports. Furthermore, each program is monitored by federal project officers at least once every three years, or on an as needed basis. Fiscal oversight is monitored by Federal Project Officers and the Grants Management Staff. Another assessment of grantees activities is the administrative review form which is prepared by Federal regional project officers, identifying whether the grantee is new or a continuing applicant, what the monitoring status is, and identifying any material weaknesses.

Evidence: The assessment is based on grantee monitoring reports, administrative review forms, and site visits protocol documents. Semi-annual progress reports and financial status reports are due to Federal Project Officer and the Grants Management Office.

3.CO3 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: YES Question Weight: 10%

Explanation: Data is collected and compiled through the biannual Report to Congress. Annual performance data is summarized and made available on the ACF's web site. RHYMIS data on performance by state or community is available to the public.

Evidence: The assessment is based on agency GPRA reports, Report to Congress and published on the National Clearinghouse for Youth website (www.ncfy.com) or FYSB website (http://www.acf.hhs.gov/programs/fysb)

Program Assessment Rating Tool (PART)

Program: Runaway and Homeless Youth
Agency: Department of Health and Human Services
Bureau: Family and Youth Services Bureau (FYSB)
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	
100%	38%	90%	0%	Results Not Demonstrated

4.1 Has the program demonstrated adequate progress in achieving its long-term performance goals? Answer: NO Question Weight: 25%

Explanation: As noted in 2.1, these measures are under development, and as such, there is not yet any progress toward the goals. FYSB is developing a new long-term outcome goal that is ambitious and relates to the mission of the transitional living program. The goal is to maintain a targeted number of youths who obtain and maintain jobs upon successfully exiting the transitional living program 6 to 12 months after they leave the program.

Evidence: Under development. FY 2005 GPRA plan. FYSB plans to increase by 2 percentage points each year, 8 percent by FY 2009 the number of youths who remain employed or full time students 6-12 months after completing the program. The purpose of the goal is to help youth successfully transition to adulthood and increase economic independence and self sufficiency.

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: NO Question Weight: 25%

Explanation: The FY 2002 baseline is not comparable to previous years due to the reconfiguration of the RHYMIS data collection system. FY 02 is the first full year of data.

Evidence: The evidence is reflected in the RHYMIS FY02 reports. RHYMIS Grantee Performance Reports 97% of grantees reporting data to RHYMIS.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: NO Question Weight: 25%

Explanation: As noted in 3.4, while the program does have procedures in place to achieve efficiencies and cost effectiveness, there are no measures in place by which to capture such efficiency gains. For example, the program has demonstrated improved efficiencies through improved RHYMIS software. The increased rate of grantee compliance with RHYMIS data submission is up to 97% in FY 02, compared to FY 01 (95%), FY 00 (84%) and FY 99 (74%). Using data collected from the new RHYMIS indicate that 165,000 youth entered the BCP at the cost of $260 per youth, the approx. cost for youth in the TLP program is $9,400 which includes all services and housing. The SOP serves 517,000 youths at the cost of approx. $29 per youth.

Evidence: RHYMIS Compliance Reports.

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: NA Question Weight: 0%

Explanation: As noted in 1.3, there is no other federal program that specifically addresses the needs of runaway and homeless youth who are considered to be "non-system youth" (i.e. outside the juvenile/criminal justice and child welfare system). FYSB staff are not aware of any comparable private, State or local government programs.

Evidence: HUD purpose and goals and Independent Living Program purpose and goals.

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results? Answer: NO Question Weight: 25%

Explanation: As noted in 2.6, there is no independent evaluation conducted on a regular basis.

Evidence: N/A

PART Performance Measurements

Program: Runaway and Homeless Youth

Agency: Department of Health and Human Services

Bureau: Family and Youth Services Bureau (FYSB)

Measure: Increase the number of youth who remain employed or full time students 6 to 12 months after successfully completing the transitional living program.

Additional Information:

Year	Target	Actual	**Measure Term:** Long-term
2004	*To be determined		

Measure: Increase the proportion of youth living in safe and appropriate settings after exiting the runaway and homeless youth programs.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2002		89.5%	
2003		89.6%	
2004	91%		
2005	92%		

Measure: Increase the percentage of youth who are either employed or are a full time student after completing the transitional living program.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2002		0.48	
2003	0.49		
2004	0.5		
2005	0.51		

PART Performance Measurements

Program: Runaway and Homeless Youth

Agency: Department of Health and Human Services

Bureau: Family and Youth Services Bureau (FYSB)

Measure: Increase the proportion of youth that enter an RHY shelter or basic center program through outreach efforts.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2002		3.4%	
2003		7.6%	
2004	9%		
2005	10%		

Measure: 2002 - Establish the number of RHY youth who are engaged in community service and service learning activities while in the program.2003-2006 - Increase the number of RHY youth who are engaged in community service and service learning activities while in the program.

Additional Information:

Year	Target	Actual	**Measure Term:** Annual
2002	0.077		
2003	0.09		
2004	0.1		
2005	0.11		

Program Assessment Rating Tool (PART)

Program: Rural Health Activities
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
60%	75%	70%	58%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The Health Resources and Services Administration's (HRSA) Office of Rural Health Policy advises the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes on rural areas. The Office also oversees Outreach Grants expanding access to, coordinate, and improve quality of health care services. Rural Health Network Development Grants encourage providers to partner in formal networks to integrate administrative, clinical, financial, and technological functions across organizations. State Offices of Rural Health funds operation of these offices. Rural Access to Emergency Devices provides grants to community partnerships to purchase equipment and provide defibrillators and basic life support training. Rural Hospital Flexibility Grants to states help stabilize and improve access to services and develop and implement state rural health plans. The Small Hospital Improvement Program helps these hospitals implement the prospective payment system, comply with HIPAA, and improve hospital performance. Denali Commission funds are used to construct primary health care facilities in Alaska.

Evidence: Section 711 of the Social Security Act (42 USC 912) authorizes HRSA's Office of Rural Health Policy. Included is the authorization for the programs it oversees: 1) Outreach Grants Section 330A of the Public Health Service Act (42 USC 254c) 2) Rural Health Network Development Grants Section 330A of the Public Health Service Act (42 USC 254c) 3) State Offices of Rural Health Section 338J of the Public Health Service Act (42 USC 254r) 4) Rural Access to Emergency Devices Public Law 106-505 Subtitle B, Section 411-413 5) Rural Hospital Flexibility Grants Section 1820(c) of the Social Security Act (42 USC 1395i-4) 6) Small Hospital Improvement Program Section 1820(g)(3) of the Social Security Act (42 USC 1395i-4) 7) Denali Commission Public Law 105-277, Section 304

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: Approximately 65 million Americans reside in rural areas, of which the Rural Policy Research Institute (see Evidence/Data column) estimates that approximately 7 million live in poverty (25 percent higher than in urban areas). Non-elderly people living in rural poverty are more likely than their urban counterparts to lack health insurance. Population shifts over the last decade from urban to rural areas has changed the racial and ethnic makeup of communities. Many growing rural counties are experiencing concurrent growth in the diversity of its residents and in general rural areas have a higher proportion of elderly residents, primarily in the South and Midwest. Minorities often move to distinct rural communities where poverty is high and opportunity is low and in general the elderly use more health services than the non-elderly. Cigarette use by adolescents ages 12-17 in 1999 is higher in rural areas (19%) than urban areas (11%), adults living in rural counties are most likely to smoke (27% of women and 31% of men in 1997-1998), and the percent of women with obesity is highest in rural counties (23%). These trends illustrate the health disparities that exist in rural areas.

Evidence: 1) http://www.rupri.org The Rural Policy Research Institute provides objective analysis and facilitates public dialogue concerning the impacts of public policy on rural people and places. 2) CDC/NCHS Urban and Rural Health Chartbook 2001

Program: Rural Health Activities
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
60%	75%	70%	58%	

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: NO Question Weight: 20%

Explanation: Redundancy and duplication exist. More than one program across the Department addresses the same problem, interest, or need--rural health. In July 2001, the Secretary of HHS charged all agencies to examine ways to improve and enhance health care in rural areas. HHS created a Rural Task Force, which identified more than 225 health and social services programs within HHS of which: 33% provide grants for which rural communities can directly apply (including IHS programs), 25% are block grants or other funding to States, and 42% are funding to national organizations, academic institutions, and Congressionally-mandated projects. Within this array of programs there are clearly some programs that consistently reach into rural communities, most notably the HRSA Community Health Centers (27% in rural zip codes), IHS, CMS, and programs administered by SAMHSA and the AoA. Efforts are in place to help minimize duplication. Applicants are required by law to note any other sources of federal funding and to distinguish how it is being used in a manner that would alleviate concerns about duplicate or redundant financial support. The majority of the Office's funding (75%) is used for activities that would not overlap with other HHS resources.

Evidence: HHS Rural task Force Report to the Secretary, July 2002

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: NO Question Weight: 20%

Explanation: The major flaw of the Office's portfolio stems from the programs authorization. The Office's portfolio consists of seven programs that each focus on a small part of the total. A less stovepipe and more seamless effort in rural areas could help maximize access, generate effectiveness, yield cost efficiencies, and reduce the number of specific projects and geographically targeted projects funded each year.

Evidence: HHS Rural task Force Report to the Secretary, July 2002

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: YES Question Weight: 20%

Explanation: The Office's programs are specifically designed to address health needs in rural communities. Through demonstrations the Office supports creative models of outreach and offers flexibility for rural communities to identify needs. The Office also focuses on the smallest most vulnerable rural hospitals through the Flex and Small Hospital Improvement programs.

Evidence: The Offices Small Hospital program has assisted more than 700 of the smallest, most vulnerable hospitals

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation: OMB and HRSA recently developed two long-term output goals that link to the mission of the program.

Evidence: 1) FY 2005 GPRA Plan 2) See "Measures" tab for the long-term goals

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation: When developing these long-term goals, specific attention was paid to highlighting baseline data and ensuring ambitious targets.

Evidence:

Program Assessment Rating Tool (PART)

Program: Rural Health Activities
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
60%	75%	70%	58%	

2.3 **Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** Answer: YES Question Weight: 12%

Explanation: OMB and HRSA recently developed two annual output and outcome goals that demonstrate progress toward achieving the long-term goals for patient safety activities.

Evidence: 1) FY 2005 GPRA Plan 2) See "Measures" tab for the annual goals

2.4 **Does the program have baselines and ambitious targets for its annual measures?** Answer: YES Question Weight: 12%

Explanation: When developing these annual goals, specific attention was paid to highlighting baseline data and ensuring ambitious targets.

Evidence:

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: NO Question Weight: 12%

Explanation: The overarching long-term goals have not been articulated in RFAs, contracts, cooperative agreements, or interagency agreements. RFAs are written to include themes, but themes are not identical to those goals laid out for the program. Project Officers use these themes as they perform their annual site visits with each grantee.

Evidence:

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: YES Question Weight: 12%

Explanation: In 2002, the University of Minnesota Rural Health Research Center conducted an evaluation of the long-term success of the Rural Health Outreach Program. It evaluated 104 former grantees whose projects started in 1994 or 1996 and examined whether services implemented with Outreach program funds continue to be provided three-five years after funding ended. In addition, three program assessments have been conducted on the Network Development Grant Program. The assessments studied network organizational structure, management, financing services, leadership, and sustainability.

Evidence: 1) University of Minnesota Rural Health Research Center Evaluation 2) TA Contractor for Rural Health Network Development Grant Program

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: Prior to the recent development of overarching long-term and annual goals, the program did not have clear and articulated performance goals they drove the budget formulation process. As a result, budget requests were not developed to request funding levels designed to achieve performance.

Evidence:

Program Assessment Rating Tool (PART)

Program: Rural Health Activities
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
60%	75%	70%	58%	

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: HRSA attempts to hold all parties accountable by specifying annual goals in contracts goals negotiated with the contractor as part of their performance based contract plans. Contractors are required to commit to tasks contributing to those performance goals and file reports by phone weekly, and written monthly and annual reports. If progress is judged as insufficient agreements may be terminated. In addition, the Office will add to all of its program guidance for the 2005 cycle information about its strategic plan and its long-term and annual performance goals for the program. This will provide grantees the necessary context to understand the Office's overarching goals of increasing the health and wellness of people living in rural communities and ensuring the viability and sustainability of rural hospitals.

Evidence:

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 10%

Explanation: The Office independently evaluates all of its programs once they have been implemented long enough to gain experience and uses that information to revise and improve program guidance and management. Program guidance for all programs is assessed annually and refined to reflect compliance with the authorizing statutes, address any valid concerns of grantees over administrative burden and to protect program integrity. In addition, the Office regularly convenes project officers at the conclusion of each funding cycle to review the past year's activities, identify program strengths and weaknesses and develop strategies for addressing weaknesses. The Office then works with Grants Management personnel in making any needed changes. In making contracts, the Office reviews each contract quarterly and requires project officers to ensure that tasks are carried out in a timely manner consistent with the contract requirements.

Evidence:

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 10%

Explanation: For the first time in FY 2002, each Office grant program manager created a strategic plan. As part of each employee's mid-year and annual performance review, they are assessed on their administration of the particular grant program they work with and on any contracts for which they served as Project Officer. This includes compliance with timelines developed jointly by management and staff and for use of resources and ensuring that grants are awarded appropriately. Staff performance ratings also hinge on their work as Project Officers. The Office is required to adequately review all contracts on a quarterly basis to ensure contractors are meeting deadlines and adhering to the requirements of the contract. For each of the Office's grant programs, Project Officers are required to perform non-competing continuation reviews of grantees annually. In those situations where a problem with a grantee arises, the Office conducts an inquiry into whether or not the problem should have been identified in the course of the annual non-competing continuation review and corrective actions are taken as necessary.

Evidence:

Program: Rural Health Activities
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
60%	75%	70%	58%	

3.3 Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose? Answer: YES Question Weight: 10%

Explanation: Since the inception of these programs all funds were obligated and disbursed in a timely manner, following specific legislative requirements. HRSA monitors grantee expenditures to ensure compliance with legislation, regulation and policies.

Evidence: 1) Estimated obligations by quarter in apportionments for FYs 2001-2003 2) Actual obligations by quarter for FYs 2001-2003

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution? Answer: NO Question Weight: 10%

Explanation: The program does not have procedures in place to measure and achieve efficiencies and cost effectiveness. In addition, the program's performance plan does not include efficiency measures and targets that address such things as per unit cost of care and/or treatment or other measures directly linked to the mission of the program.

Evidence:

3.5 Does the program collaborate and coordinate effectively with related programs? Answer: YES Question Weight: 10%

Explanation: The Office works with HRSAs Health Professions training programs and CMS on options for providing technical assistance or potential grants to rural communities interested in using the Medicare PACE model (Program of All-Inclusive Care for the Elderly). The Office will jointly issue a contract to provide some technical assistance on this issue to rural communities in August 2003. The Office also works with HUD in its administration of the 242 Capital program to provide an avenue for Critical Access Hospitals (CAHs) to gain access to the capital markets. As a result of this collaboration, the HUD program has created special rules that take into account the small scale of CAHs with a refined application process. HRSA also works cooperatively with IHS to assist with the predominant number of American Indian and Alaska Natives living in isolated rural areas.

Evidence:

3.6 Does the program use strong financial management practices? Answer: NO Question Weight: 10%

Explanation: The September 30, 2002 and 2001 independent auditor's report identifies five reportable conditions. 1) Preparation and analysis of financial statements - HRSA's process for preparing financial statements is manually intensive and consumes resources that could be spent on analysis and research of unusual accounting. 2) HEAL program allowance for uncollectible accounts HRSA's financial statements indicate limited success in collecting delinquent HEAL loans. 3) Federal Tort Claims Liability HRSA is unable to estimate its malpractice liability under the Health Centers program. 4) Accounting for interagency grant funding agreements HRSA's interagency grant funding agreement transactions are recorded manually and are inconsistent with other agencies procedures. 5) Electronic data processing controls HRSA has not developed a disaster recovery and security plan for its data centers. Although HRSA's rural health programs have not been cited specifically by auditors for material weaknesses, the above reportable conditions constitute weaknesses within HRSA and its Office of Financial Integrity. The Office reports directly to the Administrator and is intended to ensure procedures are in place to provide oversight of all of HRSA's financial resources.

Evidence: 1) CORE Accounting Form 2) HRSA Office of Financial Integrity description 3) HRSA FY 2001-2002 Annual Reports

Program ID: 10001065

Program Assessment Rating Tool (PART)

Program: Rural Health Activities
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
60%	75%	70%	58%	

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 10%

Explanation: HRSA is streamlining its grants operations and increasing efficiency through an electronic grant application process; the Office will be part of that transition. In addition, for the 2004 cycle for Outreach and Network grants, the Office has begun an initial letter-of-intent requirement. The previous requirement only asked applicants to let the State Office know an applicant was applying at the time of submission. State Office representatives noted that this was too late in the process to identify situations where applicants from the same community might be applying for funds for similar or overlapping projects. State Offices can now provide more assistance on the front end in and identify potential areas of overlap in terms of proposals. HRSA also developed a corrective action plan to address the reportable conditions identified in the September 30, 2002 and 2001 independent auditor's report. For each aspect of the five reportable conditions, HRSA assigned an office responsibility. The plan also outlines milestones and target completion dates.

Evidence: HRSA Corrective Action Plan for FY2002 Financial Statement Audits as of 4/30/2003.

3.CO1 Are grants awarded based on a clear competitive process that includes a qualified assessment of merit? Answer: YES Question Weight: 10%

Explanation: Program applications for nationally announced competitive grant cycles are reviewed by objective review committees. The committees review the project plan and budget based on criteria announced publicly in the application guidance. Funding decisions are made based on committee assessment, relative need, announced funding preferences, program priorities, and, beginning in FY 2004, periodic on-site reviews. The Outreach and Network development grants are time-limited demonstration grants for three years. The Office announces new grants under the HRSA Preview announcement and encourages new and first-time applicants to apply. State Offices of Rural Health encourage communities to apply for these grant programs. Technical assistance is made available through the State Offices and directly to any entity seeking assistance with the process.

Evidence:

3.CO2 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: YES Question Weight: 10%

Explanation: Program and project officers review grantee continuation applications. Award recipients submit audits that are appropriate for their type of organization and level of funding. All grantees submit quarterly cash transaction reports indicating the current amount of cash spent to the Payment Management Office. Grantees also provide a yearly Financial Status Report to the Office of Grants Management Operations which identifies the amount of Federal funds spent for the budget period and how much is unobligated. The original application and progress reports are reviewed for information on how grant funds will be spent. The program staff identifies areas where problematic expenditures are noted and contacts the grantee for explanation and correction if necessary. There have been very few instances where funds have been expended outside of their intended purpose. The Agency is developing an integrated performance review program for all of its programs, which will include site-evaluation of selected rural health grantees.

Evidence:

Program Assessment Rating Tool (PART)

Program: Rural Health Activities
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
60%	75%	70%	58%	

3.CO3 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: NO Question Weight: 10%

Explanation: Data are not made available to the public in a transparent and meaningful manner. The Office does post some key data about the performance of its grantees on the web. In the past two years, the Network Development Grant program and the Outreach program developed source books of all grantees that include financial and narrative information. The Office will also begin systematically reviewing the number of hits on its web site and use that information to help refine the type and format of information that is available.

Evidence:

4.1 **Has the program demonstrated adequate progress in achieving its long-term performance goals?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: New measures have been developed and the Office will begin establishing baselines and quantifying the progress of rural hospitals. However, the Office has been monitoring for three years the financial performance data for its 353 hospitals that have been converted to critical access hospitals. Reports show that average operating margins for these hospitals has improved since 1996. Profit margins have increased from -4.1% in 1996 to 1% in 2000.

Evidence: The Rural Hospital Flexibility Program Tracking Project (February 2003 Report)

4.2 **Does the program (including program partners) achieve its annual performance goals?** Answer: SMALL EXTENT Question Weight: 25%

Explanation: The annual GPRA measures for the Outreach and Network grants established in FY 98 demonstrate incremental progress towards the long-term goal by providing access to services. From the base year of FY 98, when the program served 630,000 rural residents, the program has served more than 670,000 every year, with a peak year in 2000. The program has received level funding during that period. In FY 2002, the program served 673,700 rural residents.

Evidence:

4.3 **Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** Answer: LARGE EXTENT Question Weight: 25%

Explanation: The Flex, Outreach, Network, and Research grant programs have received level funding for the past three years. Despite this and increased expenses for grantees, these programs continue to maintain or expand services. Capacity building and infrastructure development are key Office activities. The Office maximizes its technical assistance capacity by working with the 50 State Offices of Rural Health to train the trainer in grant writing, small hospital performance improvement, and economic modeling. In turn, these State Offices assist local communities to prepare grant applications, improve local hospital performance and networking, and determine those services that might be offered through local resources. In addition, the grant programs seek to develop networking and sustainable partnerships. Projects funded through the outreach grant program have demonstrated sustainability; nearly 90 percent of the grantees continues a significant portion of their activities three years after the end of the grant project period.

Evidence: University of Minnesota Rural Health Research Center Evaluation

Program ID: 10001065

Program Assessment Rating Tool (PART)

Program: Rural Health Activities
Agency: Department of Health and Human Services
Bureau: Health Resources and Services Administration
Type(s): Competitive Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
60%	75%	70%	58%	

4.4 **Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?**

Answer: NA Question Weight: 0%

Explanation: No other programs fund the wide array of activities funded by the Office.

Evidence:

4.5 **Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?**

Answer: YES Question Weight: 25%

Explanation: Evaluations of several office programs indicate that the Office is effective and achieving results in increasing access to services in rural communities. For example, the 2002 evaluation by the University of Minnesota Rural Health Research Center indicates that the majority of Outreach grantees surveyed continue to provide health services in rural communities. These services were made possible by initial support from the Office. In addition, ongoing assessments in the Network and Flex programs indicate that the strength and viability of rural health organizations and infrastructure increases.

Evidence: University of Minnesota Rural Health Research Center Evaluation

Program ID: 10001065

PART Performance Measurements

Program: Rural Health Activities

Agency: Department of Health and Human Services

Bureau: Health Resources and Services Administration

Measure: Percentage of critical access hospitals with positive operating margins

Additional Information: The overarching goal is to increase the financial viability/sustainability of small rural hospitals.

Year	Target	Actual	**Measure Term:** Long-term
1999	Baseline	10%	
2010	35%		

Measure: Average operating margin of critical access hospitals

Additional Information: To be a CAH, a hospital must: 1) Maintain no more than 15 acute care beds and up to 10 swing beds; 2) Keep patients hospitalized no longer than 96 hours; 3) Provide 24 hour emergency care; and 4) Be designated by the state.

Year	Target	Actual	**Measure Term:** Annual
1999	Baseline	-1.5	
2005	+0.5		
2006	+0.5		
2007	+0.5		
2008	+0.5		

Measure: Proportion of rural residents of all ages with limitation of activity caused by chronic conditions

Additional Information: The overarching goal is to address health disparities in rural areas by increasing the health and wellness of people living in rural communities.

Year	Target	Actual	**Measure Term:** Long-term
2000	Baseline	14.6%	
2010	13.9%		

PART Performance Measurements

Program: Rural Health Activities

Agency: Department of Health and Human Services

Bureau: Health Resources and Services Administration

Measure: Number of people served by outreach grants

Additional Information:

Year	Target	Actual
2002	Baseline	673,700
2005	+1%	
2006	+1%	
2007	+1%	
2008	+1%	

Measure Term: Annual

OMB Program Assessment Rating Tool (PART)

Block/Formula Grant & Competitive Grant Programs

Name of Program: Ryan White

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The purpose of the Ryan White (RW) CARE Act is to ensure care and treatment for persons with HIV. Under the original authorization the program focused only on care for people living with AIDS. The reauthorization redirects the focus on the disease at the stage of HIV--prior to its progress to AIDS (the more fatal state of progression). The CARE Act authorizes assistance to localities disproportionately affected by HIV, States, and other public or private nonprofit entities to provide for the development, organization, coordination and operation of systems for the delivery of essential services to individuals and families with HIV.	1) Authorized 1990-1995 (P.L. 101-381) under Title XXVI of the Public Health Service Act (PHS). 2) Reauthorized 1996-2000 (P.L. 104-146). 3) Reauthorized 2000-2005 (P.L. 106-345). . NOTE: The authorizing language for Title I refers to this title as providing emergency assistance.	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	When the epidemic began in the United States in the mid-1980s the focus on care and treatment were for disenfranchised populations. The face of AIDS has changed over time. Increased numbers of young people, women, and minorities are now being diagnosed as HIV positive.	CDC estimates approximately 850,000-950,000 persons live with HIV. One-third of those persons are in medical care, one-third know their status but are not in medical care, and one-third do not know their status. An estimated 533,000 duplicated persons (4.1 million health-related visits) receive HIV medical care and related supportive services through RW programs. CDC estimates 40,000 new infections occur each year.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The RW program is the payer of last resort and is the only Federal HIV care and treatment program that assures the provision of appropriate therapies and support services to sustain the lives of underinsured and uninsured individuals with HIV. Specifically, RW provides access to medical interventions such as highly active antiretroviral therapies. It is estimated that 70 percent of HIV patients begin treatment late.	Funding for RW has grown from $108 million in 1990 to $1.9 billion proposed in the FY 2003 Budget. HRSA is the third largest (behind Medicaid and Medicare) single source of Federal funding for health care for low-income, uninsured, and underinsured Americans living with HIV. More than half of those living with HIV receive services under the CARE Act. These interventions have contributed to the decline in both new AIDS cases and AIDS-related deaths. The number of AIDS cases has declined from 47,915 in 1998 to 42,156 in 2000. Also, deaths due to HIV-related causes declined from 18,397 to 15,245 during the same time.	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	When the epidemic began in the United States there was an immediate need to ensure care and treatment for disenfranchised populations infected with HIV/AIDS. These populations were being denied employment and health insurance, the sickness became debilitating, and death was imminent. It was necessary to address this disease head-on and specifically. Ryan White resources filled that gap and thus made a unique contribution to addressing the problem. With the help of Ryan White, those living with HIV/AIDS are living longer and are able to continue working. In many ways HIV/AIDS is becoming a "chronic disease". As drug treatments are improved, the epidemic continues on its current course, and policy officials assess the need for Federally-funded programs that provide care and treatment only to persons with a specific disease, it is possible the answer to this question will change. Federal health care (such as Community Health Centers) and insurance programs already include those living with AIDS in their service populations and could continue to do so.		20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Is the program optimally designed to address the interest, problem or need?*	No	The CARE Act is designed in such a way that duplication in the services provided exists among Titles. In addition, the CARE Act stipulates that funding for most of Title I and II is to be allocated based on the number of cases of AIDS over 5 years. The Title II ADAP Supplemental is also being allocated according to this formula. The HIV/AIDS community has expressed concern that this does not take into consideration the level of sickness or need of these individuals. National Alliance of State and Territorial AIDS Directors is beginning to think about/discuss the CARE Act reauthorization for 2005 with these concerns in mind. The consulting firm Booz, Allen, and Hamilton has found that: 1) the HIV/AIDS Bureau (HAB) administers CARE Act programs, services, and activities as "silos" and 2) there is not a clear or consistent concept of HAB's vision/mission. NOTE: HAB has begun taking corrective actions to ensure better coordination across Titles.	Booz, Allen, and Hamilton Organizational Assessment and Management Plan Development (Oct. 2001).	20%	0.0
Total Section Score					**100%**	**80%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning (Yes,No, N/A)						
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	RW activities are addressed in HRSA's 5-year plan. In addition, OMB and HRSA/HAB recently developed ambitious long-term outcome goals that link to the mission of the program. In some cases baseline data are unavailable for FY 2004, but HAB believes these data can be collected for FY 2005. In addition, the 2000 RW reauthorization includes a directive for the Institute of Medicine (IOM) to conduct a study examining the availability and utility of health outcome measures and data for HIV primary care and support services funded by RW, and the extent to which those measures can be used to measure quality of funded services. The IOM has convened a multidisciplinary study committee to address these issues. The final report will be issued at the end of the project in October 2003.	HRSA/HAB's newly developed long-term outcome goals are: 1) Reduce deaths due to HIV infection below 3.6 per 100,000 people by 2010, 2) Increase the national proportion of people living with HIV receiving primary medical care and treatment to 50 percent by 2010, 3) Increase by 10 percent the number of racial/ethnic minorities and by 2.5 percent the number of women served by CARE Act-funded programs by 2010, and 4) All CARE Act-funded HIV primary medical care providers will have implemented a quality management program and will meet two "core" standards included in the PHS Clinical Practices Guidelines for Treatment of Adults, Adolescents, and Pregnant Women by 2010.	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	HRSA's annual GPRA plan includes many annual goals, many of which are process-oriented. OMB and HRSA/HAB recently developed discrete, quantifiable, and measurable annual performance goals that demonstrate progress toward achieving the long-term goals.	A few of HRSA/HAB's newly developed annual goals are: 1) Increase by 2 percent annually the number of persons who learn their serostatus from RW programs, 2) Serve a proportion of racial/ethnic minorities in RW-funded programs that exceed their representation in national AIDS prevalence data by a minimum of 10 percentage points annually, and 3) Increase the proportion of new RW HIV-infected clients who are tested for CD4 and viral load counts.	14%	0.1
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	As part of the condition of the grant award, all competitive and formula grant recipients must submit through the CARE Act Data Report (CADR) system data detailing the number of clients served, client characteristics, and services delivered., which assists with contributing to national trends and specifically provides information on the impact of RW outreach efforts. HAB and program-level goals and performance expectations are clearly stated in the annual guidance. Any criteria used to review and score applications are stated in the program announcement/application.	1) Title I - HIV Emergency Relief Grant Program FY 2002 Application Guidance. 2) Title II - FY 2002 Application Guidance. 3) Title III Planning Grant Program and Capacity Building Grant Program Technical Assistance conference calls. 4) Title IV - Grants for Coordinated HIV Services and Access to Research for Children, Youth, Women, and Their Families FY 2002 Grant Application Guidance. 5) http://hab.hrsa.gov/reports/data2a.htm.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	Medicaid and Medicare programs are closely related programs with similar goals and objectives. CMS has sent a letter to State Medicaid Directors in November 1998 urging them "to implement strategies to improve coordination between the Medicaid program and the programs of the Ryan White Comprehensive AIDS Resources Emergency Act. ... This letter specifically addresses the need for State Medicaid agencies to cooperate with Ryan White grantees to ensure that Medicaid pays for Medicaid-covered services for Medicaid-eligible individuals with HIV disease to conserve the limited funds approrpiated for Ryan White programs." HRSA and CDC also collaborate between care/treatment and prevention/surveillance activities, which are essential to creating and maintaining high quality systems of care. HRSA also coordinates with substance abuse and mental health services programs. Also, many of the RW grantees are community health centers.	1) CDC Surveillance data and reports. 2) November 25, 1998 letter from CMS' Center for Medicaid and State Operations Director to State Medicaid Directors.	14%	0.1
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	A number of assessments and quality evaluations of Title I and II programs have been conducted every three to five years by GAO and the IG's Office to fill gaps to support program improvements and evaluate effectiveness. These independent reviews are from non-biased parties with no conflict of interest. Also the 2000 reauthorization directs the IOM to conduct studies regarding the availability and utility of health outcome measures and data for HIV primary care and support services. In addition, HHS' Office of HIV/AIDS Policy has been conducting a review of the management of HIV programs across the Department. Other evaluations are mandated by the CARE Act; however, these evaluations are conducted by Planning Councils or grantees and would not be considered non-biased.	1) March 2000 GAO report "Use of Ryan White CARE Act and Other Assistance Grant Funds". 2) November 1995 GAO report "Ryan White CARE Act: Opportunities to Enhance Funding Equity". 3) IOM Health Outcomes Assessment due in 2003.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	HRSA's OMB budget justification and Congressional justification display the line item for Ryan White. However, when HRSA submits its budget request to the Department for review, the annual targets are adjusted according to the funding level requested and/or the final funding level provided by the Department, not based on estimates generated from a model/mechanism in place that allows for cost per unit of service/marginal dollar change projections. HRSA has made improvements in its internal control system by integrating planning and budgeting and developing annual targets associated with the program activity; however, HRSA has not yet moved to being able to make budget decisions using a more precise and detailed system of costing that is also linked to adjusting targets to achieve the established long-term and annual performance goals.	1) OMB Budget Justification submitted each Fall. 2) Congressional Justification submitted each February with the President's Budget.	14%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	Booz, Allen, and Hamilton is conducting an organizational assessment and management plan to define the new operating vision and new operating framework, which will help it plan on an integrated basis, evaluate performance collectively, and allow HAB to identify, assess, prioritize, and manage areas in need of organizational improvement.	Booz, Allen, and Hamilton Organizational Assessment and Management Plan Development (Oct. 2001).	14%	0.1
Total Section Score					**100%**	**86%**

Section III: Program Management (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	HAB regularly collects data from its grantees via its CARE Act Data Reporting system. Because all data is now collected electronically for all Titles, the timeliness and credibility of the data continues to improve. HAB also reallocates funding if grantees are not using funds consistent with plans.	1) Site visit checklist and reports. 2) Grantee progress reports. 3) Grantee financial status reports. 4) http://www.hab.hrsa.gov/report_studies.htm	12%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The Director of HAB has a performance contract with the Administrator of HRSA that links to the performance results set by the program. Grantees are also held accountable for cost, schedule and performance results and are periodically visited by a team of expert consultants to assess performance. Based on the information obtained, program decisions regarding continued funding, including appropriateness of funding levels are made. Grantees are required to address any outstanding recommendations in their annual application for continued federal funding and file notification of funds expended/obligated/unexpended and unobligated/unexpended within 90 days of the completion of their budget year.	1) Program managers performance contract. 2) Site visit reports. 3) Booz, Allen, and Hamilton Organizational Assessment and Management Plan Development (Oct. 2001).	12%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	No	There are some cases when grantees or subgrantees do not use their funds according to statute. Most of these cases stem from subgrantees improperly managing resources, and the grantee of record identifies the problem. At that time legal actions are taken, funds are returned, and/or individuals must pay restitution. HRSA/HAB has obligated its funding by quarter fairly consistently over the years. The majority of funds are obligated within the first two quarters. Financial status reports show minimal unobligated balances. HAB monitors grantee expenditures to ensure compliance with legislation, regulation and policies.	1) Estimated obligations by quarter in apportionments for FYs 1999-2001. 2) Actual obligations by quarter for FYs 1999-2001. NOTE: All grantees expending above $300,000 in Federal funds provide Single Audit Act reports.	12%	0.0
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	The program's performance plan does not include efficiency measures and targets that address such things as per unit cost of care and/or treatment or other measures directly linked to the mission of the program. Competitive sourcing activities occur for non-governmental duties requiring special expertise; otherwise, the process of administering and monitoring this program is treated as inherently governmental. Booz, Allen, and Hamilton has found that: 1) HAB administers CARE Act programs, services, and activities as silos and 2) there is not a clear or consistent concept of HAB's vision/mission.	1) CADR - HRSA/HAB's information technology efforts center around standardizing data collection, so that HAB may measure such things as the number of people served or the number of health-related visits. 2) In addition, the Department's Unified Financial Management System is under development. 3) Booz, Allen, and Hamilton Organizational Assessment and Management Plan Development (Oct. 2001).	12%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program's annual budget requests are not derived in such a way that full annual costs associated with achieving annual goals are included in the submission, either formally or informally. HRSA, like most other agencies across government, develops its budget using the reverse methodology. They identify the funding level, then increase or decrease their annual targets according to the funding level proposed.	1) Estimated obligations by quarter in apportionments for FYs 1999-2002. 2) Actual obligations by quarter for FYs 1999-2002.	10%	0.0
6	*Does the program use strong financial management practices?*	No	HRSA financial statements are conducted by the Program Support Center. Staff reviewed financial reports within a five year time frame for which there was an internal control material weakness identified for Ryan White activities in 2000. Although HRSA is making improvements the FY 2000 Annual Report includes the following statement regarding fluctuations in net cost for the year, "HIV/AIDS costs increased by twenty-eight percent ..., over amounts reported in its fiscal 1999 financial statements. Management could not initially provide explanations for these fluctuations, which indicates a lack of complete understanding of the operating results reflected in HRSA's accrual basis financial statements...".	FY 1997-2001 HRSA Annual Reports.	11%	0.0
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	HRSA is working with Booz, Allen Hamilton to begin correcting management deficiencies.	Booz, Allen, and Hamilton Organizational Assessment and Management Plan Development (Oct. 2001).	11%	0.1
8 (B 1.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	Grant applications, conditions of awards, site visits, and year end reports either identify or track how funds are expended, unobligated amounts remaining, and plans for carryover balances.		5%	0.1
9 (B 2.)	*Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	Data are collected from grantees and are published each calendar year and made available to grantees and the public on the HAB website (hard copies are also available). The website also includes a map of the United States that allows queries for grantee data by state.	1) http://hab.hrsa.gov/reports/data2a.htm 2) http://hab.hrs.gov/data/hab2000/index1.htm	5%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
10 (Co 1.)	*Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?*	Yes	The Division of Community Based Programs' Objective Review Committees (ORCs) review and evaluate Titles III and IV competing grant applications based on program-specific criteria. ORC recommendations are based on applicants' responsiveness to the published guidance.	ORC documentation of application reviews.	5%	0.1
11 (Co 2.)	*Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	Yes	Pre-application technical assistance for each competing grant announcement is available to all prospective applicants. Outreach is also made to faith-based and community based organizations. From 1998 to 1999, 22 new awards were made. From 1999 to 2000, 63 new awards were made. From 2000 to 2001, 65 new awards were made. Faith-based estimates are forthcoming.	1) HRSA Preview. 2) Federal Register. 3) Catalog of Federal Domestic Assistance. 4) http://hab.hrsa.gov/tools.htm and hab.hrsa.gov/grants.htm. 5) Notice of funding availability mailings to faith-based and community-based advocacy organizations.	5%	0.1
Total Section Score					**100%**	**55%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Large Extent	Since HAB did not previously have long-term outcome goals and has not been measuring these specific goals, actual RW performance/impact for a few of these goals can not yet be measured. Thus, a Yes answer could not be granted this year. The RW program has contributed to the overall decline in the number of AIDS cases and deaths due to HIV, as well as the increase in the number of persons receiving primary medical care and treatment.	The number of AIDS cases has declined from 47,915 in 1998 to 42,156 in 2000. Also, deaths due to HIV-related causes declined from 18,397 to 15,245 during the same time. See more details below.	20%	0.1

Long-Term Goal I: **Reduce Deaths**	Reduce deaths due to HIV infection below 3.6 per 100,000 people by 2010.
Target:	3.6 deaths per 100,000 persons by 2010.
Actual Progress achieved toward goal:	5.4 deaths per 100,000 persons in 1999; 15.4 deaths per 100,000 persons in 1994.
Long-Term Goal II: **Improve Access to Care and Treatment**	Increase the national proportion of people living with HIV receiving primary medical care and treatment to 50 percent by 2010.
Target:	50 percent nationally by 2010.
Actual Progress achieved toward goal:	33 percent nationally in 2000 (estimated).

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Long-Term Goal III: **Reduce Health Disparities**	Increase by 10 percent the number of racial/ethnic minorities and by 2.5 percent the number of women served by CARE Act-funded programs by 2010.				
	Target:	406,230 racial/ethnic minorities served by 2010; 164,000 women served by 2010.				
	Actual Progress achieved toward goal:	369,300 racial/ethnic minorities served in 2000; 347,500 racial/ethnic minorities in 1998. 160,000 women served in 2000; 157,000 women served in 1998.				
	Long-Term Goal IV: **Improve Quality of Care and Treatment**	All CARE Act-funded HIV primary medical care providers will have implemented a quality management program and will meet two "core" standards included in the PHS Clinical Practices Guidelines for Treatment of Adults, Adolescents, and Pregnant Women by 2010.				
	Target:					
	Actual Progress achieved toward goal:	TBD (Data to be available in 2003).				
2	*Does the program (including program partners) achieve its annual performance goals?*	Large Extent	The RW program has enhanced provider access to a wide-array of medications to treat persons with HIV as well as reduced barriers to public HIV services and care, thus leading to an increase in the number of persons who learn their serostatus. Since some of the OMB/HRSA-agreed upon annual goals are new and baseline data are not available a Yes answer could not be granted this year.	Early Intervention Services served 129,654 clients in FY 2000, thereby exceeding HRSA's goal by 17.4%, which is an increase of 15.8% over the number of new clients served in FY 1999. See more details below.	30%	0.2
	Key Goal I: **Linked to L-T Goal I**	Increase the number of AIDS Drug Assistance Program (ADAP) clients receiving HIV/AIDS medications through State ADAPs during at least 1 month of the year by at least 4 percent.				
	Performance Target:	4 percent per year.				
	Actual Performance:	Receiving medications through State ADAPs: 73,784 in 2001, 70,357 in 2000, 62,881 in 1999, 55,000 in 1998.				
	Key Goal II.A: **Linked to L-T Goal II**	Increase by 2 percent every second year the number of persons provided services through the Ryan White CARE Act program.				
	Performance Target:	2 percent every second year.				
	Actual Performance:	533,000 in 2000 (estimate based on modeling). 500,000 in 1998 (estimate based on modeling).				
	Key Goal II.B: **Linked to L-T Goal II**	Increase by 2 percent annually the number of persons who learn their serostatus from Ryan White CARE Act programs.				
	Performance Target:	2 percent per year.				
	Actual Performance:	352,283 individuals in 2000. Trend data is forthcoming.				

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Key Goal III.A: **Linked to L-T Goal III**	Serve a proportion of racial/ethnic minorities in CARE Act-funded programs that exceed their representation in national AIDS prevalence data by a minimum of 10 percentage points annually.				
	Performance Target:	10 percent per year.				
	Actual Performance:	62.1 percent of all persons living with AIDS nationally in 2000 were minorities; 60 percent of all persons living with AIDS nationally in 1997.				
	Key Goal III.B: **Linked to L-T Goal III**	Serve a proportion of women in CARE Act-funded programs that exceed their representation in national AIDS prevalence data by a minimum of 5 percentage points annually.				
	Performance Target:	5 percent per year.				
	Actual Performance:	20.6 percent of all persons living with AIDS nationally in 2000 were women; 19.1 percent of all persons living with AIDS nationally in 1997 were women.				
	Key Goal IV.A: **Linked to L-T Goal IV**	Increase 5				
	Performance Target:	5 percent per year.				
	Actual Performance:	TBD (estimated 50-60 percent of current grantees for 2002).				
	Key Goal IV.B: **Linked to L-T Goal IV**	Increase the proportion of new CARE Act HIV-infected clients who are tested for CD4 count and viral load.				
	Performance Target:					
	Actual Performance:	Trend data to be available mid-2004.				
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Large Extent	Many of the measures have been monitored by HRSA overtime and show improved performance. In addition, Ryan White demonstrates cost effectiveness by contributing to the increased number of drugs on formularies and States involved in discount drug purchasing programs.		25%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	NA			0%	
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Small Extent	Report findings include: RW resources are reaching vulnerable and underserved groups (minorities and women), RW addresses the growing spread of HIV in rural areas, RW funds are most often used for medical treatment and medications, and compensation to administrators is generally comparable with similar nonprofit organizations. However, these evaluations do not address the quality of the Ryan White program.	March 2000 GAO report "Use of Ryan White CARE Act and Other Assistance Grant Funds".	25%	0.1
Total Section Score					**100%**	**59%**

OMB Program Assessment Rating Tool (PART)

Block/Formula Grants

Name of Program: State and Community-Based Services Programs on Aging (Title III, Older Americans Act)

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The purpose of Title III of the Older Americans Act (OAA) is to assist State and local agencies on aging to enter into new cooperative arrangements in order to concentrate resources and expand the capacity to provide comprehensive and coordinated systems in each state. The objectives of the Title III programs (congregate meals, home-delivered meals, supportive services and centers, preventive health care, and support of family caregivers) are to: (1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services; (2) remove individual and social barriers to economic and personal independence for older individuals; (3) provide a continuum of care for vulnerable older individuals; and (4) secure the opportunity for older individuals to receive managed in-home and community-based long-term care services.	The purpose and objectives of Title III - Grants for State and Community Programs on Aging, are found in Section 301(a) of the OAA.	20%	0.2
2	*Does the program address a specific interest, problem or need?*	Yes	The elderly suffer higher levels of disease and disability than other population age groups. Title III provides an array of services to reduce vulnerability to and the effects of disease and disability in order to allow vulnerable elderly individuals to remain in their homes. Title III provides meals to elderly individuals in congregate and home settings; transportation to senior centers, medical appointments, and other venues in the conduct of daily business; services to family members who care for the elderly; and preventive health services, such as exercise programs in senior centers.	A meta-analysis of nutrition studies showed that almost two thirds of older persons were at nutritional risk. Recent AoA data show that 87% of new clients in the Congregate Nutrition Program have high (37%) or moderate (50%) degrees of nutritional risk. Data from the CSFI (USDA) and the the Behavioral Risk Factor Surveillance System indicate significant areas of nutritional deficits among the older population. A May 1999 GAO report, "Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services," states: "obtaining personal care on what is often a daily basis is critical for avoiding institutionalization."	20%	0.2

3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The federal role in the Title III programs is to provide funding (as a formula grant based on the proportion of older individuals residing in the state), establish the Aging Network infrastructure, support program development, and foster consistency of service across the Aging Network while allowing program flexibility. The OAA established Aging Network consists of 56 state and territory agencies on aging, 655 area agencies, 10,000 senior centers, approximately 29,000 community service providers, and an estimated 500,000 volunteers.	The programs serve approximately 7 million people each year, and provide intensive and in-home services to approximately 3 million individuals each year. Over 40% of the staff of area agencies on aging across the country are volunteers. The Network leverages approximately $1.90 for every $1 AoA provides for services.	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	No other federal program provides the combination of services contained in Title III. By design, Title III provides the infrastructure for State and Area Agencies on Aging, and the related service providers, which integrates funding from State and local sources along with federal funds. This infrastructure (commonly referred to as the "Aging Network") provides the leadership to insure that State and local support continues as service systems evolve.	Mathematica evaluation: "Serving Elders at Risk: A National Evaluation of Older Americans Act Nutrition Programs" (1996). Title III of the OAA.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	Funding for the Title III community-based services program is determined by formula (based on the number of persons 60+ in the state) and provides flexibility to State and local entities to target the needs of the elderly in communities. This approach has generated positive system results for the program as indicated by leveraging of funds, program income generated, and participation by volunteers. The flexibility of the State and local entities to transfer dollars among programs enhances program design.	States and communities leverage about $1.90, and raise $0.30 in revenue, for every OAA dollar. Over 40% of the staff of area agencies on aging are volunteers. In accordance with OAA Section 308 b(4)C, States are able to transfer funds among services (e.g., from congregate meals to supportive services) to meet local needs.	20%	0.2
Total Section Score					**100%**	**100%**

Section II: Strategic Planning (Yes,No, N/A)						
	Questions	**Ans.**	**Explanation**	**Evidence/Data**	**Weighting**	**Weighted Score**
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	No	The goals are not limited to the scope of the program or the targeted population, are not outcome based, and there is not an efficiency goal. Moreover, the goals and measures need to indicate a baseline, clear timeframes and targets, and strive to improve program performance.	AoA's FY 2003 annual performance plan.	14%	0.0
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	No	While some of AoA's annual measures support the long term goals, others do not. AoA's annual goals focus on maintaining performance, rather than making progress toward long-term improvements. Some measures are set below historic performance levels.	AoA's FY 2003 annual performance plan.	14%	0.0
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	No	AoA does not have the authority to require state or local agencies to adopt the AoA goals. However, state and area agencies were consulted in the identification of performance measures for GPRA plans, and state and local data is used for each of the measures. State plans include performance measures.	AoA supports grants and cooperative agreements with States for Performance Outcome Measurement Projects (POMP) to develop improved outcome measures which meet both Federal, State, and local needs. Twenty states currently participate in the POMP program.	14%	0.0
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	On the Federal level, AoA coordinates with other programs to provide information, guidance and funds to state and local agencies. The OAA also supports the infrastructure of the Aging Network, which encourages collaboration on the state and local level, and shares information on best practices as well as how collaboration can be enhanced.	State Program Reports. Examples of AoA interagency collaboration to assist the Aging Network includes developing with the Center for Medicare and Medicaid Services the Real Choice Systems Change grants announcement, and the Nursing Home Quality Improvement Initiative statement of work. Examples of Federal-state collaboration: (1) 31 state agencies on aging administer the Medicaid Home and Community-based Services waiver program; and (2) AoA, the Centers for Disease Control and state agencies on aging and health departments are developing an integrated system of health promotion for the elderly.	14%	0.1

5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	The AoA evaluates major programs on a 10-year basis. The most recent evaluation of the OAA Nutrition Programs, by Mathematica Policy Research, was released in 1996. The other programs under Title III were not explicitly included in this evaluation, though it acknowledged that the nutrition programs could not be fully disaggregated from the other support programs.	AoA staff indicated the process for the next program evaluation will begin in FY 2003 with discussion involving relevant stakeholders, development of a statement of work, consultation with HHS' Assistant Secretary for Planning and Evaluation, and deliberations within AoA. AoA intends to integrate aspects of other Title III programs in this evaluation.	14%	0.1
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	AoA's budget and GPRA program structures are the same to foster the use of GPRA program results to support AoA budget requests. AoA states its funding priorities for its budget request are based on observations made directly from GPRA program reports and other program data. It does not appear that the effect of funding, policy or legislative changes on performance is readily known.	AoA annual performance plan and congressional justification.	14%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	No	AoA does not have a systematic process in place to proactively identify deficiencies. AoA's ongoing program management identifies problems as they arise and works to correct any deficiencies. AoA does not view its current system of performance goals and measures as a deficiency.	Evidence of a systematic process was not provided.	14%	0.0
Total Section Score					**100%**	**29%**

Section III: Program Management (Yes,No, N/A)						
	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	Yes	AoA has a National Aging Program Information Systems (NAPIS) through which the states annually submit detailed aggregate data on the services provided by the Title III program (State Program Reports - SPR) as well as the characteristics of program participants. AoA reviews, validates, and certifies this program data. Improvements in this process have greatly shortened the time needed by the States to submit this data and the time needed for review and certification by AoA. AoA added 8 intermediate outcome measures addressing improvements by States.	The NAPIS/SPR data is used directly in AoA GPRA outcome measures to set objectives for state performance. AoA and the States have reduced annual data lags by 11 months over the last three years. FY 1998 data was certified in February, 2001 - 29 months after the end of FY 1998; FY 1990 data was certified in September, 2001 -- 23 months after the end of FY 1999; and FY 2000 data was certified in April, 2002 -- 18 months after the end of FY 2000.	11%	0.1
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	It is the responsibility of AoA managers to pursue improvement of program management and performance; their contracts link to GPRA performance measures. AoA does not have the authority to hold State and local agencies accountable; however, AoA does assist agencies that fall short of their goals to identify and fix deficiencies. While OAA funding is determined by formula as specified in the OAA, there are incentives to encourage better performance, including additional funds based on the number of meals provided in the nutrition programs, as well as for states to improve performance measurement (POMP project).	AoA manager performance contracts.	11%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	Federal funds for this program are made available within a few days after the appropriation act is signed by the President. This is consistent with the intent of Congress. Grantees (States) provide semi-annual Financial Status Reports to show that the funds are spent for the intended purposes. Future grants are not awarded unless the grantees comply with expenditure requirements.	Financial management requirements. SF 269. Single State Audits.	11%	0.1

4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	The Title III programs do not have policies to decrease unit costs or a clear efficiency goal. Title III of the OAA is a formula grant based on the number of persons aged 60+ in the state as compared to the number of persons 60+ in the United States as a whole.	AoA annual performance plans. The formula for the Title III state allotment is in Section 304 (42 USC 3024) of the OAA.	11%	0.0
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	AoA does not use full cost accounting. While AoA's current budget includes all direct and indirect costs that are charged to the agency, it does not do so on a program level. AoA has not linked changes in program performance to changes in funding level.	AoA FY 2003 Justification of Estimates for Appropriations Committees	11%	0.0
6	*Does the program use strong financial management practices?*	Yes	While exercising sound financial management control within AoA, the agency utilizes the financial management services of HHS and the Program Support Center for the vast majority of its financial management processes and activities. AoA has achieved two consecutive clean opinions in financial statement audits, and no material weaknesses were identified in those audits.	AoA Financial Statement Audit Memos.	11%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	No	AoA does not have a system in place to proactively identify deficiencies. Rather, the OIG of HHS monitors audit issues for timely resolution. AoA has not received any material issues related to this program.	Description of ad hoc process for identifying deficiencies provided by AoA.	11%	0.0
8 (B 1.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	The grantees are required to submit a state or area plan on a periodic basis which are reviewed and approved by AoA staff. AoA staff performs annual site visits to the State Units on Aging. AoA Regional Office personnel are also in continuous contact with the States.	Copies of state plans are maintained in AoA for review by internal and external groups. These plans are reviewed as part of the Financial Audit.	11%	0.1

9 (B 2.)	*Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	AoA collects, compiles and disseminates program performance data on an annual basis through the National Aging Program Information System, which includes standardized electronic submission, and formal verification, validation and certification processes. Upon certification, data for all States are disseminated to the public via the Internet and other mechanisms, including GPRA reports.	All of the State Program Reports may be viewed on the AoA web site at: http://www.aoa.gov/napis	11%	0.1
Total Section Score					**100%**	**67%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	No	The performance goals in the AoA Strategic Plan build on the existing GPRA goals. These goals need to be better targeted, have clear baselines and timeframes, and strive to improve program performance.	AoA FY 2003 annual performance plan.	25%	0.0

Long-Term Goal I:	Target Services to vulnerable elderly individuals
Target:	38% will live in rural areas
Actual Progress achieved toward goal:	33%
Long-Term Goal II:	Integrate Federal, State, local funds for elderly
Target:	Increase leveraged funding by 20%
Actual Progress achieved toward goal:	Current is $1.90 for every AoA dollar
Long-Term Goal III:	Increase the impact of OAA Programs on the older population
Target:	Increase the proportion of the elderly population served by OAA programs to 17%
Actual Progress achieved toward goal:	15%

2	*Does the program (including program partners) achieve its annual performance goals?*	No	Although the program met its annual goals, in some cases the targets were set below historic actual performance.	AoA FY 2003 annual performance plan.	25%	0.0

Key Goal I:	A significant percent of OAA clients live in rural areas
Performance Target:	34% in FY 2003
Actual Performance:	33% (based on FY 1999 and FY 2000 data)
Key Goal II:	Maintain a high ratio of leveraged funds to AoA funds
Performance Target:	$1.90 leveraged for every $1.00 from AoA in FY 2003
Actual Performance:	$1.90 (based on FY 1999 and FY 2000 data)
Key Goal III:	Maintain a high ratio of volunteer staff in area agencies
Performance Target:	40%
Actual Performance:	45% (based on FY 1999 and FY 2000 data)

3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	No	The programs have not demonstrated improved efficiencies and cost effectiveness in achieving the program goals, as written. AoA indicated that the combination of goals for leveraged funds and increasing the population served will implicitly lead to efficiencies, but none have been demonstrated explicitly.	AoA GPRA reports show that performance has been maintained but not improved.	25%	0.0
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	N/A	There are no similar federal programs. The results are consistent across AoA's programs for home and community services. AoA's results incorporate performance of State and local programs managed by the Aging Network.		0%	

5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Yes	The 1996 evaluation of the nutrition programs found: 1) nutrition of clients better than non-clients; 2) improved social interaction; 3) leveraged funding; 4) coordinated service access and delivery with health and social services; and 5) effective targeting of the vulnerable. The evaluation did not find any significant program deficiencies. AoA indicated that future evaluations would include other components of the Title III programs.	Mathematica evaluation: "Serving Elders at Risk: A National Evaluation of Older Americans Act Nutrition Programs" (1996).	25%	0.3
Total Section Score					**100%**	**25%**

Program Assessment Rating Tool (PART)

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

1.1 Is the program purpose clear? Answer: Yes Question Weight: 20%

Explanation: The purpose of SCHIP is clearly described in Title XXI of the Social Security Act (SSA); provide funds to States to initiate and expand health care coverage to uninsured low-income children in conjunction with other third party insurers.

Evidence: The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP) and provided new funds for states to cover uninsured children. This program represents the largest single expansion of health insurance coverage for children in more than 30 years and aims to improve the quality of life for millions of vulnerable children less than 19 years of age. Under Title XXI of the Social Security Act, states were given the option to set up a separate child health program, expand Medicaid coverage, or have a combination of both a separate child health program and a Medicaid expansion.

1.2 Does the program address a specific interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: SCHIP addresses the need for health insurance coverage by uninsured, low-income children under the age of 19 with family incomes between Medicaid income levels and 200 percent (and above) of the Federal Poverty Level (FPL). In 2001, the Census Bureau's Current Population Survey (CPS) estimated that the number of uninsured low-income children (defined as under 200% of the FPL) was 5.7 million. Title XXI also extended coverage to uninsured parents whose children are eligible for SCHIP. There is evidence that enrolling parents under 1115 demonstrations and HIFA waivers promotes the enrollment and retention of children in SCHIP and increases utilization of services (see section IV). States may use Title XXI funds to insure parents and other adults, but covering children must remain the highest priority. States cannot cap enrollment of children or institute waiting lists; the priority must be on children over adults. States must ensure that SCHIP funds are available for children over the life of a demonstration that includes parents or other adults.

Evidence: By September 1999, all States and jurisdictions had approved SCHIP plans. Currently, 19 States have separate child health programs, 15 States and D.C. expanded Medicaid coverage, and 16 States have a combination of both programs. States continue to shape their programs through SCHIP state plan amendments. As of April 2002, there have been 155 amendments to SCHIP plans and 12 states have approved section 1115 SCHIP demonstrations to enroll even more children and families. Recently, seven HIFA waivers also were approved (AZ, CA, NM, IL, CO, NJ, and OR) using unspent SCHIP funds. Coverage is now available for children whose income is 200 percent of the Federal poverty level (FPL) or higher in 38 states and the District of Columbia. Prior to this legislation, only six states had income eligibility levels at or above 200 percent for infants only.

Program Assessment Rating Tool (PART)

Program:	State Children's Health Insurance Program
Agency:	Department of Health and Human Services
Bureau:	Centers for Medicare & Medicaid Services
Type(s):	Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

1.3 Is the program designed to have a significant impact in addressing the interest, problem or need?

Answer: Yes

Question Weight: 20%

Explanation: SCHIP provides an enhanced match rate on health coverage expenditures for uninsured low income children. The enhanced match rate has provided incentives to States and jurisdictions to expand coverage above Medicaid levels. The implementation of SCHIP has increased children's coverage and access to health care to a much greater extent than Medicaid alone. For example, in separate child health programs, SCHIP is not an entitlement, which many States have cited as a determining factor in expanding coverage for children. For States with Medicaid expansion SCHIP programs, the enhanced match has served as an incentive to expand coverage. Apart from the implementation of SCHIP programs, SCHIP has had a positive effect on state Medicaid programs. States have reported that many of the children applying for SCHIP are actually eligible for Medicaid and are enrolled in Medicaid. Also, the outreach and simplification efforts started in SCHIP have "spilled over" to Medicaid and resulted in significant improvements. In addition, many states are implementing premium assistance or employer sponsored insurance (ESI) programs. In ESI programs, the states pay all or part of premiums for group health insurance coverage of an eligible child or children, and employers often pay part of the premium. There currently are 7 states with approved premium assistance programs in SCHIP: Maryland, Massachusetts, Mississippi, New Jersey, Virginia, Wisconsin, and Wyoming. States may also apply for family coverage 1115 waivers under SCHIP, which allows them to purchase coverage for the entire family if it is cost effective. The states with family coverage waivers are Maryland, Massachusetts, Virginia, and Wisconsin.

Evidence: SCHIP enrollment figures show a continued and consistent rise in the numbers of children ever enrolled in SCHIP. In fiscal year (FY) 2002, 5.3 million children were ever enrolled in SCHIP, which is an increase of 700,000 children, or 15 percent, over the 4.6 million children ever enrolled in FY 2001. The 5.3 million children ever enrolled in FY 2002 is more than 2.5 times as many children ever enrolled in FY 1999 and more than four times as many children ever enrolled in calendar year 1998. In comparison to Medicaid, SCHIP has allowed States greater flexibility to change or vary premiums, benefit packages, and delivery systems, as well as subsidizing employer sponsored insurance (ESI) programs. Also refer to Section I, Question #2. SCHIP 1115 demonstrations and HIFA waivers also provide States with additional flexibilities in administering their SCHIP programs. Medicaid data show that enrollment was slow to steady in the early 1990s prior to SCHIP, but began to increase in the late 1990s with the inception of SCHIP.

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

1.4 Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)? Answer: No Question Weight: 20%

Explanation: Although SCHIP was designed to focus on the health needs of children, Medicaid and SCHIP have extremely similar functions: To provide health care insurance coverage to low-income people. Currently, many children under age 19 whose family incomes are at or below 100% of the FPL are covered under Medicaid. Prior to Title XXI, States already had the option to increase coverage levels for children under Medicaid or under State-only programs. Health insurance coverage for children has been and could be further expanded under Medicaid. As highlighted in questions 2 and 3 above, SCHIP has had a positive impact on Medicaid eligibility and enrollment; more states now cover children to higher income levels in Medicaid and SCHIP. Medicaid enrollment has increased, and correspondingly the number of uninsured children has decreased since the inception of SCHIP. SCHIP has given States more flexibility to tailor their children's health insurance programs to individual State needs than under Medicaid. Screen and enroll, and crowd out provisions included in the SCHIP regulation also have ensured that eligibility levels and coverage provided through SCHIP funds is not duplicative of Medicaid or private insurance.

Evidence: Refer to section 457.805 of the SCHIP regulation for crowd out provisions and section 457.80(c) for regulatory language on SCHIP coordination with other health insurance coverage. States monitor and report on crowd out to CMS in their annual reports. SCHIP annual reports can be found on the CMS website. The primary method used by states in FY 2001 for preventing crowd out was the imposition of a period during which the applicant must be uninsured prior to enrollment in SCHIP. Thirty-three states (67 percent) reported using periods of uninsurance to prevent crowd out in at least a part of their SCHIP program. Reported periods of uninsurance imposed by states ranged from 1 to 12 months, with 3 and 6 months cited as the most common periods. In addition, a report issued by the Urban Institute in June 2001, Has the Jury Reached a Verdict? States Early Experiences with Crowd Out under SCHIP, found that states did not have a high incidence of crowd out. A copy of this report can be found on the Urban Institute website. Also refer to Section I, Question #2.

1.5 Is the program optimally designed to address the interest, problem or need? Answer: Yes Question Weight: 20%

Explanation: The SCHIP formula allocates funds based on each State's uninsured and low-income populations of children as measured by the Current Population Survey (CPS). The allotment formula is designed to concentrate funds in States with the most uninsured children. In addition, it caps Federal liability and gives states flexibility to design their programs and expand coverage. The allotments also serve as a balance to state flexibility in that states are at risk for their choices in designing and expanding coverage. Since the inception of SCHIP in 1997, however, many States have come to rely on multiple years of funding to cover current year program costs. While the redistribution of unspent funds helps States that spend their yearly allotments, States are not guaranteed a set amount of funding and cannot depend on receiving these funds each year. In addition, some States that have expanded to similar coverage levels have large unobligated balances while other States spend most or all of their allotted funds. Currently, the Administration and Congress are considering several proposals that would alter how unspent SCHIP funds are redistributed.

Evidence: Refer to sections 2104(b) (description of the SCHIP formula) and 2104(f) (description of the reallotment process) of the Social Security Act. See the Census Bureau website for the report "The Characteristics of Persons Reporting State Children's Health Insurance Program Coverage in the March 2001 Current Population Survey." The authors point out some of the problems with using the CPS to measure the number of uninsured children, especially in smaller States, in part due to the survey's small sample size for making individual State estimates. Congress specifically has appropriated additional funds to continue to improve both the health insurance questions and sample sizes used in the CPS (See section 2109(b) of the Social Security Act).

Program ID: 10000306

Program Assessment Rating Tool (PART)

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

2.1 Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?

Answer: No Question Weight: 16%

Explanation: Title XXI states that the main long-term goal of SCHIP is to expand health assistance to uninsured, low-income children. To this end, CMS has a long term SCHIP GPRA goal to increase the number of children enrolled in Medicaid or SCHIP. When the State Children's Health Insurance Program began in 1997, CMS implemented an enrollment goal to enroll five million children by FY 2005. In order to quantify this objective, CMS set annual GPRA targets for FYs 2000 through 2002 to enroll at least one million new children in SCHIP and Medicaid per year. CMS is changing the targets for FY 2003 and 2004 to increase enrollment by five percent over the previous year. This change was made because the program has exceeded the annual GPRA targets for FYs 2000 - 2002 and because states are facing fiscal challenges that may affect program outreach and enrollment, which makes forecasting enrollment difficult. In future years, the ability to achieve this new goal may be impacted by the fiscal situation in the States, increases in the uninsured rate as a result of changes to the U.S. economy, and changes to estimates of the uninsured due to changes in the CPS. In FY03, CMS began developing a GPRA goal to improve health care quality across Medicaid and SCHIP through the Performance Measurement Partnership Project (PMPP). The purpose of this goal is to work with States to establish a core set of quality performance measures that States will report on annually. When fully implemented, these core measures/goals will demonstrate the progress toward the long-term goal of improving health care quality. In 2003, states will be required to report to CMS on these core measures in their annual reports, to develop baselines. However, the program cannot receive full credit until both baselines and long-term targets for the seven SCHIP core performance measures have been developed. HHS should also develop specific and ambitious long-term outcome goals with baselines and targets for SCHIP for the FY06 budget beyond increasing enrollment. Changes in this score will occur only when there is significant evidence to demonstrate results in these areas.

Evidence: Please reference the FY 2004 Annual Performance Plan and Report: 1) Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program, FY 2004 APP, p. VI-65; 2) Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid, FY 2004 APP, p. VI-69. PMPP performance measure examples include: 1) number of well-child visits; 2) access to primary care services; 3) quality of diabetes care; 4) timeliness of prenatal care. CMS will send a request to states in September, 2003 to submit data on the PMPP performance measures in their 2003 annual report.

2.2 Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?

Answer: Yes Question Weight: 16%

Explanation: CMS collects performance data from each state. The SCHIP statute requires all states to describe their strategic objectives, performance goals, and performance measures in their state plans. States report to CMS annually on the progress of their performance via annual reports including their progress towards reducing the number of uninsured children in their annual reports. By statute, state annual reports are due to the Secretary by January 1 following the end of the fiscal year. In addition to increasing the number of children enrolled in Medicaid and SCHIP, States have expanded SCHIP eligibility levels. Thirty-eight States and the District of Columbia now have SCHIP income eligibility thresholds of 200% or more of the federal poverty level. Only three states had income eligibility levels this high for children in Medicaid prior to the enactment of the SCHIP program.

Evidence: Refer to sections 2107 and 2108 of the Social Security Act. State annual reports can be found on the CMS website.

Program ID: 10000306

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

2.3 Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program? Answer: Yes Question Weight: 16%

Explanation: SCHIP regulations include reporting requirements for States on their individual progress towards meeting strategic and performance goals. These goals are outlined in State plans and reported in annual reports. Many States have set performance goals related to quality and satisfaction of care, and enrollment goals. Information from state plans and annual reports in July 2001 indicated that only 5 States do not use any of the Health Plan Employer Data and Information Set (HEDIS) measures. All other States use all or part of the HEDIS set of measures. Most States collect data on immunizations and well child visits. In addition, States submit descriptions of progress towards enrollment goals in annual reports and must also submit quarterly and annual enrollment data. States also are required to have a plan for outreach and describe their progress in the annual enrollment reports.

Evidence: Refer to the SCHIP regulation,section 457.740(a) for enrollment data requirements and section 457.750 for annual report requirements. SCHIP regulations include reporting requirements for States on their individual progress towards meeting strategic and performance goals, which are reported in the annual reports. CMS reviewed the FY 2001 annual enrollment reports and summarized State outreach efforts as largely successful. States generally employ a variety of outreach methods. In FY 2001, many states described a multi-level approach to outreach, combining broad activities targeting a large audience (such as mass media or mass distribution of SCHIP informational materials) with more targeted, grassroots efforts (such as partnerships with community-based organizations). Mass media strategies ranged from short-term targeted advertising, such as Back-to-School campaigns, to ongoing, extensive campaigns using television, radio, newspaper, billboards and public transit advertisements. Involvement of local grassroots community-based organizations is commonplace in most states, in addition to partnerships with health departments, WIC clinics, Head Start programs, and healthcare providers. See the CMS website for further information on State outreach efforts.

2.4 Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives? Answer: Yes Question Weight: 16%

Explanation: States are required to describe in their State plans the procedures they use to accomplish coordination of SCHIP with other public and private health insurance programs including Medicaid and Title V. CMS also works with other agencies to further the goals of SCHIP. CMS and HRSA have a Memorandum of Understanding to ensure effective collaboration and coordination of SCHIP activities, particularly in the area of outreach. Multiple components of HHS and OMB review all State plan amendments, waivers and policy documents. States are required to screen children for both Medicaid and SCHIP eligibility and enroll children in the program for which they are found eligible. State screen and enroll procedures must be included in SCHIP State plans. A report by OIG in February 2001 found that children in the States they surveyed, children were being appropriately enrolled in the programs for which they were eligible.

Evidence: Refer to §457.80(c) of the SCHIP regulation, which describes SCHIP requirements for program coordination. Also see OIG report "Ensuring Medicaid Eligibles are not Enrolled in SCHIP, February 2001" on the HHS OIG website.

Program:	State Children's Health Insurance Program
Agency:	Department of Health and Human Services
Bureau:	Centers for Medicare & Medicaid Services
Type(s):	Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

2.5 **Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?** Answer: Yes Question Weight: 16%

Explanation: Every three years, the HHS Office of the Inspector General (OIG) is required to review SCHIP's progress toward reducing the number of low-income uninsured children and properly enrolling Medicaid-eligible children in Medicaid. The General Accounting Office (GAO) is required to monitor the OIG's reports. OIG has issued two reports, one on screen and enroll procedures and the other on the annual evaluations submitted by states. OIG found no problems with State's screen and enroll procedures and CMS concurred. However, CMS will continue to monitor this issue and continue to work with the states to improve screen and enroll processes. On the annual evaluations, OIG recommended that CMS develop a core set of measures and improve the evaluation report framework. CMS, the National Academy for State Health Policy (NASHP), and the states collaborated on a new and improved framework that the states used for the FY 2002 annual reports. CMS, NASHP, and the states are currently working on a web-based annual report template. OIG is currently in discussions with CMS on two future studies of SCHIP. One study will revisit the screen and enroll issue and the other study will assess state progress towards reducing the number of uninsured children as measured by states in the strategic objectives sections of their the annual reports.

Evidence: Refer to Section 2108(d)(1) of the Social Security Act. The three OIG reports, "Assessment of State Evaluation Reports, February 2001", "State Children's Health Insurance Program (SCHIP) Renewal Process, September 2002", and "Ensuring Medicaid Eligibles are not Enrolled in SCHIP, February 2001" can be found on the HHS OIG website. The GAO report, "Children's Health Insurance: Inspector General Reviews Should be Expanded to Further Inform the Congress, March 2002" can be found on the GAO website. See evidence document for study websites.

2.6 **Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?** Answer: N/A Question Weight: 16%

Explanation: This does not apply since SCHIP funds are alloted to states. The allotment is prescribed by statute and the amount of the allotment cannot be changed in response to program performance. However, each state acts as its own administrative agent and the allotments serve as a balance to state flexibility in that states are at risk for choices in designing and expanding coverage. States must align budgets and goals in order to ensure that the capped SCHIP allotment will cover the costs of the program.

Evidence: Section 2104 of the Social Security Act describes the allotment and reallotment process.

Program Assessment Rating Tool (PART)

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

2.7 Has the program taken meaningful steps to address its strategic planning deficiencies? Answer: Yes Question Weight: 16%

Explanation: Title XXI requires all States to describe their strategic objectives and measures, but there are no consistent measures across all States. The SCHIP regulations require a core set of performance measures and CMS is currently working with the National Academy for State Health Policy to develop this core set. This collaboration is referred to as the Performance Measurement Partnership Project, which will result in a single set of performance measures that will be required of all States. CMS is currently working with the states to develop the technical specifications for the measures that have been selected. A "Dear State Health Official" letter requesting some of this information will be sent to the states in July 2003. Also, CMS will convene a meeting in September 2003 with the states to finalize the specifications for the core set of performance measures. The plan is for States to begin reporting on these measures beginning in their FY 2003 Annual Reports. By statute, state annual reports are due to the Secretary by January 1 following the end of the fiscal year.

Evidence: Section 457.710 of SCHIP regulations refers to the requirement that a core set of performance measures be established for SCHIP. In 2003, CMS is requiring states to collect data on the seven PMPP performance measures and report back to CMS.

3.1 Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance? Answer: No Question Weight: 14%

Explanation: Title XXI requires all states to describe their strategic objectives, performance goals, and performance measures in their state plans. States report to CMS annually on the progress of their performance via annual reports including their progress towards reducing the number of uninsured children in their annual reports. In this area, CMS's role is more oversight than operational. Since SCHIP is an insurance program that is managed by a federal/State partnership, the federal government cannot penalize or reward States for how their programs perform unless improper payments are made. States have discretion in setting capitation rates, choosing providers, etc. CMS regularly monitors enrollment growth, enrollment simplification, crowd-out, and other trends to assure that States continue to reach uninsured children. CMS has found that States are making progress in enrolling more children into SCHIP through better outreach and enrollment simplification efforts. CMS gives States feedback on their programs, discusses issues with Regional Office

Evidence: CMS collects performance data through the annual reports, on-site monitoring visit reports (conducted once every two years), and enrollment data (quarterly and annually).CMS, using information obtained from key program partners (the States), is updating and improving the framework used by States to submit their annual reports. In FY 2002, CMS changed the annual report template in response to information and feedback collected from the States. The new annual report template enables the Division of State Children's Health to more efficiently and accurately collect information from the states. The information from these annual reports is then summarized into a comprehensive annual report (which is currently under review).For FY 2003, CMS will provide an electronic form for the states to submit the annual report online, via the web. The new web-based form will further improve the efficiency of the process and the quality of the data submitted. staff, and participates in monthly calls with the SCHIP Technical Advisory Group (TAG),which consists of State Medicaid directors and HHS staff. The SCHIP regulations requirea core set of performance measures and CMSis currently working with the National Academyfor State Health Policy to finalize the specifications for this core set. This collaboration is referred to as the Performance Measurement Partnership Project, which will result in a single set of performance measures that will be required of all states. CMS is currently in discussions with its contractor, Mathematica Policy Research, to study access and utilization in SCHIP. Allotments are prescribed by statute which means that payments to states will not be affected by state performance as measured by the core set. As CMS collects more extensive performance information from the States, they will be able to utilize baseline data to set more extensive performance goals in the future. More information on this change may be found in Section II, question 5.

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

3.2 Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?

Answer: No Question Weight: 14%

Explanation: Without more extensive GPRA and annual performance measures, CMS cannot hold either its managers or the States accountable for cost, schedule, and performance results related to the SCHIP program. CMS staff, however, do follow statutory requirements, such as reviewing State plans and State plan amendments in 90 days. In addition, with Regional Office staff, CMS monitors State financial data to help assure that States are conducting their programs with fiscal integrity. Each State provides projected expenditures, annual budgets, and reports actual expenditures on a quarterly basis. CMS also assesses State budgets as part of all waiver proposals to assure that adequate funds are available to support the state's SCHIP children throughout the life of the demonstration. Since their SCHIP allotments are capped, states do have an incentive to manage their programs cost, schedule, and performance. States that do not manage their programs well are more likely to exhaust their allotments and not be able to fully fund their programs. Currently, the Administrator of CMS has a performance-based contract that is aligned with some of the performance goals of the program. Other CMS/SCHIP managers are evaluated based on performance contracts that include more process/output measures. In Fall, 2003 the SCHIP Division Director is scheduled to have new performance-based contract that is more closely linked to the program goals.

Evidence: Refer the SCHIP regulation, section 457.740(a) for enrollment data requirements and section 457.750 for annual report requirements.

3.3 Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?

Answer: Yes Question Weight: 14%

Explanation: Title XXI authorizes and appropriates the allotment amounts for each fiscal year from FY 1998 - FY 2007. By issuing grant award notices to the States and territories, CMS obligates all SCHIP funds by the end of the first fiscal year so that States have access to this funding for the entire three years in which it is available. During the course of the fiscal year, CMS issues grant awards based upon each State's request up to each State's allotment for that particular year. Through the reallotment process, States may also receive funds that have been redistributed from other States that could not spend all of their allotments. Even though HHS obligates on a timely basis all of the funds to the States, many States are carrying large unobligated balances due to the lag in enrollment associated with implementing SCHIP and the inefficiencies with the SCHIP allotment formula that results in some States receiving excess funds in relation to the number of low-income uninsured children in their States. Changes to the Current Population Survey should help address this issue.

Evidence: For each year of the SCHIP program the balance in the appropriation for Title XXI will show a zero balance indicating clearly that all funds have been obligated.

3.4 Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?

Answer: NA Question Weight: 0%

Explanation: This does not apply since SCHIP funds are allotted to States, which determine their own contracts.

Evidence:

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

3.5 Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?

Answer: NA Question Weight: 0%

Explanation: This does not apply since SCHIP funds are allotted to States, and States must keep administrative costs under 10% of their total program costs. The enabling legislation provided for State and local, but not Federal CMS administrative costs to be funded from the amounts appropriated in the BBA. State and local administrative costs are statutorily capped. The States report on these administrative costs quarterly. CMS does not budget separately for Federal administrative costs, either in terms of dollars or FTE employment.

Evidence: Refer to section 2105(c)(2)(A) of the Title XXI statute showing the 10% cap that applies to State and Local Administration.

3.6 Does the program use strong financial management practices?

Answer: No Question Weight: 14%

Explanation: The Federal Financial Management Improvement Act (FFMIA) of 1999 requires that Federal programs must assess improper payments rates and do risk assessments. In the past, CMS has not calculated error rates for SCHIP. Currently, CMS is working with the States to develop an SCHIP error rate through the Payment Accuracy Measurement (PAM) project. In FY 2004, CMS is encouraging up to twenty five states to volunteer to pilot test the CMS PAM Model in both their Title XIX Medicaid and Title XXI SCHIP programs. At the conclusion of the year, the final specifications for the CMS PAM Model will be produced in anticipation of nationwide implementation. As CMS implements the PAM Model, they will be able to track and lower improper payment rates in the future. Additionally, CMSO's Division of Financial Management conducts ongoing risk assessments at the regional offices in order to pinpoint areas of risk. The CMS reviews are periodically audited/used by the HHS OIG, the GAO, and audits conducted annually under the Single Audit Act. CMS has a structured Financial Management (FM) workplan process for SCHIP, which is updated annually. The FM workplan incorporates risk analyses, FM reviews, structured planning and FM oversight of the SCHIP program.

Evidence: CMS is soliciting States to participate in the PAM project. CMS will issue PAM grants by the end of the fiscal year to States who elect to participate in the project. See attached draft version of the CMS PAM Model which includes applications to SCHIP.The Financial Management workplan includes front end financial management on Administrative program management and Services program development (e.g., reviews of cost allocation plans, administrative claiming plans, prior approval of contracts, technical assistance), Ongoing FM Oversight/Enforcement (e.g., focused FM review on high risk areas, audit liaison, deferrals and disallowances, and data gathering and analysis), and finally Quarterly Reviews related to states Budget and Expenditure reports. One of the primary emphases in these activities is the focused FM reviews, in which risk analysis on vulnerable areas is done and specific areas of reviews in each RO are identified and implemented. With the resource constraints,these activities are conducted both with respect to the SCHIP and Medicaid programs. As the year progresses, the ROs report on their progress.

3.7 Has the program taken meaningful steps to address its management deficiencies?

Answer: No Question Weight: 14%

Explanation: Although CMS monitors states through State plan amendments, monitoring visits, data and financial reviews, they are just beginning to take adequate steps to address Federal Financial Management Improvement Act (FFMIA) requirements for SCHIP. In response to recent GAO reviews and recommendations, CMS has begun to institute a structured Financial Management (FM) workplan process for SCHIP, which incorporates risk analyses, FM reviews, structured planning and FM oversight of the SCHIP program. In order to comply with Federal Financial Management Improvement Act (FFMIA) requirements, CMS is working with the States to develop a SCHIP-error rate through the Payment Accuracy Measurement (PAM) project and will begin a pilot demonstration in FY 2004.

Evidence: See section III, question 6.

Program Assessment Rating Tool (PART)

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

3.B1 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: Yes Question Weight: 14%

Explanation: States must submit State plan amendments for all significant program changes. In order to ensure that States conduct their SCHIP programs as they described in their state plans, CMS conducts on-site monitoring visits, works with regional offices on day-to-day monitoring activities, and requires annual reports and quarterly data submission. By monitoring financial and enrollment data, CMS determines if States are utilizing their allotments to meet the goals of Title XXI. In addition, Title XXI authorizes the reallocation of funds from states that do not use them to states that need funds.

Evidence: Refer to sections 457.40(a) and 457.720 of the SCHIP regulation for a description of monitoring activities.

3.B2 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: Yes Question Weight: 14%

Explanation: CMS places the following materials for each State on the CMS SCHIP web site: State plans and amendments, annual reports, evaluations, enrollment information, and national SCHIP evaluations conducted by independent contractors. Once implemented, demonstrations are monitored through review of quarterly and annual reports, regular CMS/State communication, and site visits. CMS has funded several independent evaluations by private contractors to assess the impact of certain approved demonstrations on service delivery systems, costs, and quality of care. States with approved HIFA waivers must include an evaluation component. CMS will award a RFP contract this fiscal year both for an evaluation of the recently approved and future HIFA waivers.

Evidence: Refer to CMS SCHIP web site: www.cms.hhs.gov/schip CMS also is preparing the first annual summary of State annual reports, which will be placed on the CMS SCHIP web site.

Program ID: 10000306

Program Assessment Rating Tool (PART)

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

4.1 Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?

Answer: Small Extent

Question Weight: 25%

Explanation: There were 5.3 million children enrolled in SCHIP in FY 2002. This was an increase of 700,000 children (or 15 percent) over FY 2001. A recent CDC study also found that children are significantly more likely to be insured now than in 1997 when SCHIP was enacted. In terms of SCHIP 1115 demonstrations for parent coverage, recent studies have found that States with parent coverage are more likely to enroll children in SCHIP and Medicaid and utilize more health care services. Also, many States have observed that enrollment of parents promotes enrollment and retention of children, as well as utilization of services. CMS's enrollment GPRA goal demonstrates the annual progress towards the long-term goal of decreasing the number of uninsured by enrolling children in SCHIP and Medicaid. In FY 2003, CMS also began developing a GPRA goal to improve health care quality across Medicaid and SCHIP through the Performance Measurement Partnership Project (PMPP). The purpose of this goal is to work with States to establish a core set of quality performance measures that States will report on annually. When fully implemented, these core measures/goals will demonstrate the progress toward the long-term goal of improving health care quality. As noted in Section II Question 1, over the past year, HHS will require states to report on the seven SCHIP core performance measures to develop baselines. HHS also should develop specific and ambitious long-term outcome goals with baselines and targets for SCHIP for the FY06 budget beyond increasing enrollment. Change in this score will occur only when there is significant evidence to demonstrate results in these two areas.

Evidence: A recent Urban Institute presentation reported that in States that have expanded coverage for parents under Medicaid 81 percent of eligible children participate in Medicaid compared to only 57 percent of children in States without family-based coverage programs. A recent CDC study also found that the percent of children (17 and under) without health insurance declined from 13.9 percent in 1997 to 10.1 percent between January and September 2002. During this period, reliance on public programs for coverage was fairly constant between 1997 and 2000 at about 21 percent, but then rose to 23.4 percent in 2001 and jumped to 27.2 percent in 2002. As public coverage rose, the percent of children covered by private plans dropped from 67.1 percent in 2001 to 64.2 percent 2002. This report can be viewed on the CDC website at ttp://www.cdc.gov/nchs/products/pubs/pubd/hestats/insurance.htm. See the HHS website (http://odphp.osophs.dhhs.gov/pubs/HP2000/2010.htm) for information on Healthy People 2010. Lastly, CMS has a contract with Mathematica Policy Research, Inc. (MPR), for a number of SCHIP evaluation activities. MPR is working on a report that will describe the changes in the number of uninsured children in the U.S. relative to implementation of SCHIP and recent trends in Medicaid enrollment using data from the Current Population Survey (CPS). MPR's preliminary analysis suggests that at least half of the decline in the CPS number of uninsured children may have been due to SCHIP, with traditional Medicaid growth accounting for another 10 to 15 percent. Please reference the FY 2004 Annual Performance Plan and Report: 1) Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program, FY 2004 APP, p. VI-65; 2) Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid, FY 2004 APP, p. VI-69.

Program Assessment Rating Tool (PART)

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: Large Extent Question Weight: 25%

Explanation: CMS is making progress towards implementing core performance measures. CMS currently is working with the States and the National Academy of State Health Policy on developing a core set of performance measures that rely heavily on he Health Plan Employer Data and Information Set (HEDIS) measures but this process is in the early stages, in part because the SCHIP program is just 5 years old. HEDIS contains well established quality health measures and is administered by the National Council for Quality Assurance. New GPRA goals and annual core performance measures will further help improve the SCHIP program. Status Update: CMS is currently working with the states to develop the technical specifications for the measures that havebeen selected. A "Dear State Health Official" letter requesting some of this information will be sent to the states in July 2003. Also, CMSwill convene a meeting in September 2003 with the states to finalize the specifications for the core set of performance measures. The plan is for States to begin reporting on these measures beginning in their FY 2003 Annual Reports. By statute, state annual reports are due to the Secretary by January 1 following the end of the fiscal year.

Evidence: See evidence provided in section II, question 2. The "Status Report for the Performance Measurement Partnership Project (PMPP)" discusses how CMS and the PMPP workgroup have developed a list of 9 core performance measures related to improving the quality of care for children. Six of the nine measures already are included in HEDIS. Over the next several years, the PMPP workgroup will continue to work on implementing these measures. Refer to CMS for additional information on the PMPP workgroup Also, please reference the FY 2004 Annual Performance Plan and Report. CMS monitors: 1) Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program, FY 2004 APP, p. VI-65; 2) Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid, FY 2004 APP, p. VI-69.

4.3 Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year? Answer: NA Question Weight: 0%

Explanation: This does not apply since SCHIP funds are allotted to States. On a federal level, CMS does not have the authority to require State programs to be cost effective. As previously stated, SCHIP does not have long-term or annual performance goals that focus on cost effectiveness. Individual States, however, can assess cost-effectiveness in their own programs but these goals are not linked to Federal program goals.

Evidence: Refer to the FFMIA of 1999.

4.4 Does the performance of this program compare favorably to other programs with similar purpose and goals? Answer: Yes Question Weight: 25%

Explanation: SCHIP enrollment has increased steadily, as has Medicaid enrollment. SCHIP has also had positive effects on Medicaid. States have simplified Medicaid enrollment and many children have been enrolled in Medicaid as a direct result of SCHIP. SCHIP has changed the perception of the Administration, Congress, states, advocates, and families, of public coverage for children. SCHIP provided States with a unique opportunity to model public coverage after the private sector, allowing more flexibility on benefits and cost sharing. This was particularly important to States as they covered children with higher family incomes. Most new proposals for government expansions of coverage are modeled on SCHIP because of the strong consensus that SCHIP is a successful program.

Evidence: Refer to SCHIP Annual Enrollment Reports on the CMS webpage. For an example of changes to Medicaid, refer to CMS's "Continuing the Progress" report on the CMS website.

Program: State Children's Health Insurance Program
Agency: Department of Health and Human Services
Bureau: Centers for Medicare & Medicaid Services
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
80%	83%	43%	67%	

4.5 Do independent and quality evaluations of this program indicate that the program is effective and achieving results?

Answer: Large Extent

Question Weight: 25%

Explanation: A number of independent evaluations have found that SCHIP is effective in increasing health insurance coverage for low-income children. Data from both the 2000 CPS and from the CDC in 2001 show a decrease in the number of uninsured children (under the age of 19) compared to previous years. There still, however, are needed improvements in the program. Future program improvements need to continue to emphasize decreasing the rate of the uninsured and increasing access but in addition focus on type and quality of services. The CMS evaluation describes program design and implementation in the states, including program features and outreach strategies that encourage enrollment in SCHIP. The ASPE evaluation found that there is high enrollee satisfaction and positive attitudes toward SCHIP. SCHIP has succeeded in enrolling millions of children and has also helped to increase enrollment in Medicaid, program entry in SCHIP and Medicaid has been streamlined, states continue to improve and tailor outreach strategies, SCHIP offers good access to care, and there continues to be ongoing support for SCHIP.Both the ASPE and CMS evaluations were performed by an independent contractor.

Evidence: Mathematica Policy Research, the National Academy for State Health Policy, the Urban Institute, and HHS ASPE have evaluated the SCHIP program (See websites for each organization). In addition, the Agency for Healthcare Research and Quality (AHRQ), the David and Lucile Packard Foundation, and the Health Resources and Services Administration (HRSA) currently are funding eight research projects that include SCHIP over the next three years through the Child Health Insurance Research Initiative (CHIRI). These studies seek to uncover which health insurance and delivery features work best for low-income children, particularly minority children and those with special health care needs. CMS and ASPE both contracted with outside organizations for major evaluations of SCHIP for Congressionally-mandated reports (the executive summaries are included in the evidence document).

PART Performance Measurements

Program: State Children's Health Insurance Program

Agency: Department of Health and Human Services

Bureau: Centers for Medicare & Medicaid Services

Measure: Increase the number of children enrolled in regular Medicaid or SCHIP

Additional Information: Target:Five percent new enrollment of children over previous year Actual Progress achieved toward goal:Previous goal of enrolling 1,000,000 new children each year met in FY00, 01, and 02

Year	Target	Actual
2001	1 million	>1 million
2002	1 million	> 1 million
2003	5% Increase	
2004	Maintain 03 Levels	
2005	Maintain 04 Levels	

Measure Term: Long-term

Program Assessment Rating Tool (PART)

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

1.1 Is the program purpose clear? Answer: YES Question Weight: 20%

Explanation: The purpose of the Substance Abuse Prevention and Treatment Block Grant is to distribute by formula funds to states and territories to support substance abuse treatment and prevention services. The block grant provides financial assistance to states to plan, carry out, and evaluate activities to prevent and treat substance abuse and for related public health activities (e.g., HIV and TB). Five percent of the total is used by the agency for technical assistance, data collection and other activities. Up to five percent of state allotments can be used for administrative costs at the state level. States are required to spend no less than 20 percent on prevention. The block grant also addresses special needs such as treatment for pregnant women, women with dependent children, and intravenous drug users. Resources from the block grant can also be used to reduce the rate at which retailers sell tobacco products to minors.

Evidence: The program is authorized by sections 1921-1954 of the Public Health Service Act. The block grant's Synar amendment requires states to enact and enforce legislation to prohibit the youth tobacco sales and meet specific targets for reductions in tobacco sales to youth. The amendment calls for penalties for states that fail to achieve their targeted reductions. Agency and Congressional reports related to the program are consistent with the program purpose as outlined in the authorizing legislation. The program is run by the Substance Abuse and Mental Health Services Administration (SAMHSA).

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The program is designed to provide resources to states to pay for substance abuse treatment and prevention services. The need for substance abuse treatment and prevention services is clear and current. The agency estimates that of the resources dedicated to treatment, roughly one third support drug treatment, one third alcohol treatment, and one third co-occurring drug and alcohol.

Evidence: The 2001 National Household Survey on Drug Use and Health (NHSDUH) estimates 16 million Americans used an illicit drug in the past month, 6.1 million persons above age 12 need treatment, 5.0 million need treatment but are not getting it, and 4.6 million people who meet the criteria for needing treatment do not even recognize that they need treatment. Youths aged 12 to 17 have the second highest rates of abuse of or dependence on alcohol or an illicit drug (8%), following adults aged 18 to 25 (18%) and higher than adults aged 26 or older (5%). According to the survey, about 10 million youth aged 12 to 20 used alcohol in the past month and nearly 3 million were dependent on or abused alcohol in the past year. Over 3 million persons aged 12 to 17 had smoked cigarettes during the past month.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: YES Question Weight: 20%

Explanation: The program is not overly redundant of other Federal, state, local or private efforts. Numerous federal funding sources are available to support substance abuse treatment and prevention services. SAMHSA also provides competitive grants to state and local entities for treatment and prevention services through the Programs of Regional and National Significance. State and local entities also invest resources in this area. However, the block grant is the only federal activity designed specifically to support state-wide services to all states in this area.

Evidence: According to the agency, the block grant constitutes two of every five public substance abuse treatment dollars expended by the state level agencies funded by the block grant and in some cases states rely entirely on the grant for their substance abuse prevention efforts. Twenty-two of these state agencies reported that greater than half of their total funding for substance abuse prevention and treatment programs came from the federal block grant and 11 states reported over 60 percent and seven states reported over 70 percent. When including all public funding expended through various sources (including Medicaid, TANF, other), the block grant constitutes roughly one of every seven public substance abuse treatment dollars.

Program Assessment Rating Tool (PART)

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: The block grant is free from major design flaws that prevent it from meeting its defined objective of supporting state efforts to prevent and treatment substance use. However, improvements are needed and the agency is reviewing approaches to shift the program emphasis from set-asides and other state funding requirements to reporting on the outcomes of grant expenditures. While there are possible flaws to the distribution of funds described below, there is no strong evidence that another approach or mechanism such as competitive grants would be more efficient or effective.

Evidence: Section 1930 of the PHS Act specifies maintenance of effort requirements for states and territories. As reauthorized by the Children's Health Act of 2000, the requirement excludes non-recurring activities. Statute and regulations require states to report how they spent their grant funds and do not require reporting on the impact the funds have on individuals or targeted populations. GAO HEHS 00-50 describes patterns of state expenditures and current limitations on reporting on the outcomes of block grant funded services. Specifically, the statute and regulation requires states to report how they spent funds, not on the impact the funds have on individuals or targeted populations. The transition to a performance partnership grant is intended to increase the emphasis on outcomes, performance, and program improvements. The proposal does not include changes to the formula, eligibility, or basic functions of the block grant.

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: NO Question Weight: 20%

Explanation: The guidance requires consideration of how well funds are targeted to meet the purpose and the allocation of funds and the prevalence of drug use by state are not correlated. A 2001 internal report completed by the agency looked specifically at this issue of block grant funding allocations compared with state drug use prevalence rates from an HHS drug use survey (NHSDUH, 2001) and found no correlation. The calculation plots the amount of funding distributed in accordance with the formula in statute against prevalence. A strong correlation with prevalence would improve the chances that individuals will have the same probability of getting care regardless of where they live. It is clear, however, that states provide needs assessments and target funds to appropriate populations and maintenance of effort guards against supplantation. The age profile of the population was the best available proxy for dependence when the formula was created. Finding a data source for prevalence that is sufficiently stable and that also captures substance abuse prevention is difficult.

Evidence: The formula relies on age of population with urban weighting as a proxy for prevalence, total taxable resources, and the cost of services as determined by the cost of health care worker wages and other costs. A 1992 hold harmless provision and subsequent minimum allotment requirements have maintained funding patterns while drug abuse patterns have changed. A 1995 RAND evaluation concluded a focus on a more narrowly defined population, such as the poor and uninsured, rather than the general state population, would have a significant impact on state distributions (RAND, MR-533-HHS/DPRC, 1995). The report also found the emphasis on urban populations is incongruent with higher alcohol dependence rates in rural areas and the emphasis on 18-24 year olds does not align with prevention services. Among persons above age 12, the rate of current illicit drug use in 2001 was 8.3 percent in the West, 7.5 percent in the Northeast, 6.8 percent in the Midwest, and 6.2 percent in the South (HHS, NHSDU, 2001).

Program Assessment Rating Tool (PART)

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation: The program has adopted some new long-term outcome measures including: Percentage of clients reporting change in abstinence at discharge; and, Percentage of states that provide drug treatment services within approved cost per person bands by the type of treatment including outpatient non-methadone, outpatient methadone, and residential treatment services. The cost ranges are for outpatient non-methadone $1000-$5000, outpatient methadone $1500-$8000, and residential $3000-$10,000. Outcome measures for the prevention element of the block grant are not yet available. Age of initiation of drug use and also thirty-day use are key indicators of youth drug use. SAMHSA views the two proposed measures, age of initiation of drug use and thirty-day use, inappropriate measures for the program's prevention activities.

Evidence: For the first measure, a discharge record is created for all clients who enter and leave treatment by completion, transfer to other facilities, withdrawal from treatment before completion or death. The discharge record must completed by 30 days post discharge date. For clients who leave treatment before completion, the clinical provider conducts an assessment to provide abstinence data. The cost measure was developed based on the Substance Abuse Treatment Programs of Regional and National Significance measure. SAMHSA has been working with NASADAD, the National Prevention Network and state representatives to develop and refine performance measures for the performance partnership grants since 1995. A notice in the December 24, 2002 Federal Register describes central elements of the proposed transition to performance partnership grants. (Master Summary, NASADAD, 1997-2003; Report on Consensus Building Effort, CSAP, 2001).

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: NO Question Weight: 12%

Explanation: Baselines and targets for the long-term outcome measures that have been adopted are not yet available. Once a long-term outcome measure for prevention is adopted, baseline and targets will also be developed for the prevention measure.

Evidence: Baseline data for both measures will be available in the FY 2005 uniform block grant application.

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: YES Question Weight: 12%

Explanation: The program has adopted annual outcome and output measures. The measures include: Perceptions of harm of substance use among program participants (prevention); Percentage of clients reporting change in abstinence at discharge (treatment); and Number of persons served (treatment).

Evidence: The prevention measure captures the agency's programmatic focus on reducing risk factors and strengthening protective factors. The number of persons served is calculated using the number of admissions from the Treatment Episodes Data Set divided by 1.67, which SAMHSA believes is a reasonable estimate for the number of persons served. The current uniform application includes voluntary reporting on the number of persons served and SAMHSA intends to negotiate new reporting through the performance partnership grant process.

2.4 Does the program have baselines and ambitious targets for its annual measures? Answer: NO Question Weight: 12%

Explanation: Baselines and targets for the annual measures are not yet available.

Evidence: Baseline data for the first measure from the program are not yet available. Baseline data for the second measures will be available in the FY 2005 uniform block grant application. An estimated baseline and targets are available for the number of persons served.

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
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Type(s): Block/Formula Grant

Section Scores				Overall Rating
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80%	50%	89%	8%	

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?**

Answer: YES Question Weight: 12%

Explanation: Program managers work to ensure states support the overall goals of the block grant and measure and report on performance as it relates to accomplishing goals. States commit to the overall objectives of the block grant to provide treatment and rehabilitation services to those abusing alcohol and drugs and prevention services to prevent use and abuse. States are also asked to voluntarily report on a number of outcome measures, for example, disapproval of substance use or involvement with the criminal justice system. States include descriptions of how they will meet overarching goals of the program in state plans and reports. States are also involved in the setting of goals through planning for the transition to performance partnership grants. Commitment toward the goals of the program should increase further through this transition in coming years.

Evidence: As of 2001, 25 states reported some or all information, up from no states in 1999. States and territories include needs assessment data in their applications, but do not yet report on outcomes related to the annual and long-term goals of the block grant. A notice in the December 24, 2002 Federal Register describes central elements of the proposed transition to performance partnership grants.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?**

Answer: NO Question Weight: 12%

Explanation: No comprehensive and external evaluations have been conducted on this program. GAO has reviewed some aspects of the substance abuse block grant, including the extent to which impact data are available. The agency also conducts reviews of state activities through on-site reviews, reviews of applications, and reviews of financial audit reports. By design, accountability and evaluations have been focused on compliance with statute, including set-aside requirements, and not on the impact of the block grant. Many states also conduct evaluations, but they are not currently aggregated or reported on at the national level. Less than half of states report the ability to submit client outcome studies and the frequency, methodologies and definitions of studies vary by state (NASADAD). SAMHSA's Treatment Outcomes and Performance Pilot Studies Enhancement is designed to help states measure outcomes of substance abuse treatment from block grant funded programs.

Evidence: SAMHSA reports grantee efforts for evaluation, but no independent, comprehensive evaluations of the program are available. SAMHSA does conduct not less than ten annual state performance assessments to evaluate compliance with the statute and regulation. The assessments focus on legislative set-aside requirements and systems changes. SAMHSA also performs 15 annual state prevention system assessment reviews and provides technical assistance based on the outcomes. Sixteen states currently report follow up data and three states report on outcomes of treatment through the employment and administrative data systems. For prevention, SAMHSA conducts State Prevention Advancement and Support Project performs assessment reviews in 15 states each year and provides technical assistance based on the outcomes. The prevention state level studies are contracted out and done independently. GAO reviewed efforts to increase information on outcomes (HEHS 00-50). RAND conducted an evaluation of the funding formula in 1995 (RAND, MR-533-HHS/DPRC, 1995).

Program ID: 10001066

Program Assessment Rating Tool (PART)

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: The program does not provide a budget presentation that clearly ties the impact of funding decisions on expected performance or explains why the requested performance and resource mix is appropriate. Annual budget requests are not clearly derived by estimating what is needed to accomplish long-term outcomes. The program has different output goals and has not identified how much cost is attributed to each goal. The program is able to estimate outputs (number of persons served) per increased increment of dollars. The block grant supports 40 full time equivalent staff. Other agency program management funds are budgeted separately.

Evidence: This assessment is based on the annual budget submission to OMB and the Congress.

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: SAMHSA is currently undertaking a comprehensive strategic planning effort to address accountability, capacity, and effectiveness. A deficiency highlighted in this section relates to program budget alignment with program goals. The program is developing new long-term outcome measures, baselines and targets. Having these measures in place will further enable the program to integrate budget planning and strategic planning and determine the level of financial resources needed to obtain long-term outcomes. States were asked to report on a voluntary basis on alcohol and drug use, employment status, criminal justice involvement and living arrangements in the 2000 applications. The agency's efforts to develop a performance partnership grant will also facilitate agency commitment to and reporting on performance measures for the grant. SAMHSA also plans to pilot test an independent evaluation of several performance measures that relate to national and state goals, objectives, and targets.

Evidence: The agency reports developing performance based budgeting to strengthen the links between performance and budget. The agency's restructuring plan consolidated budget formulation, planning and Government Performance and Results Act activities within one unit. As described in a December 24, 2002 Federal Register notice, the performance partnership grant is based on a shift toward greater accountability in exchange for state flexibility to design, implement, and evaluate community-based responses to substance abuse. SAMHSA is currently working with the states to identify core measures for substance abuse treatment and prevention. The planned evaluation is to be independently conducted and focus on multiple factors, including federal programs and funding streams and state and local resources. SAMHSA has developed an evaluation contract directed toward improving program evaluation in the block grant and other SAMHSA programs.

Program Assessment Rating Tool (PART)

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 11%

Explanation: The program collects performance information on an annual basis and uses the information to manage the program and improve performance. The states submit annual uniform applications that describe past, current, and intended use of program funds. States conduct needs assessments and provide a description by state and sub-state planning areas of the incidence and prevalence of alcohol abuse, alcoholism and drug abuse, current prevention and treatment activities and technical assistance requests. The program also collects annual information on state satisfaction with agency technical assistance and the grant review process. Program performance data are also collected during onsite technical reviews. SAMHSA also uses data from national surveys to guide technical assistance efforts.

Evidence: The assessment is based on agency descriptions of actions taken based on performance information and on state annual reporting forms and plans. More than 20 States now require a percentage of their block grant funds to be allocated to implement science-based or model prevention programs. The agency's prevention system assessments provide states with specific recommendations for technical assistance to improve their prevention programs. These findings also guide agency planning efforts (Prevention System Assessment Summary Report, CSAP, 1999-2003).

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 11%

Explanation: Performance plans for managers at the Division Director level and above track to management/program objectives. Managers review state compliance with the legislative requirements and monitor expenditures through compliance reviews and single audit reports, ensure that applicable financial status reports are completed, and reconcile financial status reports to the Payment Management System. Performance Based Contracting has been initiated for all new SAMHSA contractors who hold services contracts. The transition to performance partnership grants will increase the accountability of program partners for performance results.

Evidence: The assessment is based on discussions with the agency and program manager vacancy announcements. Employee evaluations at the agency are handled by each of the agency's three centers. One planned element of the performance partnership grants is to use corrective action plans as a means of increasing accountability for performance results and making program improvements. The agency reviews state requests for waivers for maintenance of effort requirements based on extraordinary economic circumstances and notes the agency can reduce state awards if the state does not comply.

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: YES Question Weight: 11%

Explanation: The agency reports funds are obligated by the government on a quarterly basis, usually within two-three days after an application has been determined compliant with relevant requirements of the Public Health Service Act. States have two years to obligate and expend funds to sub-recipients. The agency's technical reviews have found states are generally in compliance with allowable expenditure requirements, but some states are not (Aggregate Report of Revised Core Elements Technical Reviews, CSAT, 2002).

Evidence: Agency managers review annual grantee applications to determine funds are used for the intended purpose. Agency staff also examine the states obligations and expenditures of grant funds during state technical reviews. The technical reviews found of the 32 states reviewed, 12 lapsed block grant funds during the review period and three states expended block grant funds in the criminal justice system, which is a prohibited expense.

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

3.4 Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?

Answer: YES Question Weight: 11%

Explanation: The program has some procedures in place to improve efficiencies in execution. SAMHSA has established a block grant re-engineering team to improve the efficiency of staff operations in managing the program at the federal level in time for the 2004 application process. The agency plans to switch to a web-based application system in 2004. The agency relies on an HHS service clearinghouse for many internal services. The agency is providing FAIR Act targets and appears to be making progress toward outsourcing additional services. There are also elements in the block grant that seek to limit administrative costs. For example, there is a five percent limitation on administrative costs at both the federal and grantee levels. Each state and territory uses the fiscal policies that apply to its own funds for administering the block grant. Additional steps, including adoption of measures for efficiency of operations, are needed to maintain progress in this area.

Evidence: Evidence includes the FAIR Act report, services directed to HHS consolidated Program Support Center, and Restriction of Expenditure of Grant. Outsourced activities include accounting, graphics, human resources, and property management. With the federal set-aside, there are 22 treatment project officers, including state data infrastructure activities, and 15 prevention project officers, including five associated with Synar. There is, however, continual competition for the block grant set-aside for data resources and other federal-level activities. Beginning next year, SAMHSA plans to convert the application system from Windows to an internet system for states to prepare and submit applications on line. SAMHSA projects savings associated with the new system as the independent contractor reduces staff support by 20%.

3.5 Does the program collaborate and coordinate effectively with related programs?

Answer: YES Question Weight: 11%

Explanation: The program does collaborate with related activities. For example, in the substance abuse prevention area, by design SAMHSA's prevention state incentive grants collaborate with the block grant at the federal and state level. The state incentive grants also promote changes in activities funded by the block grant and in the entire state prevention system. SAMHSA also collaborates with other federal, state, and local governments as well as non-governmental organizations. SAMHSA collaborates with HHS's Center for Medicaid and Medicare Services on the review of state Medicaid waivers and with the Office of National Drug Control Policy.

Evidence: Evidence for this question is included in the Government Performance and Results Act report, meetings, conferences, and other documentation. Examples of specific activities include work with sister offices HRSA and NIAAA on national alcohol screening day, contributions in TANF and SCHIP regional meetings, collaboration with the Administration for Children and Families, work with the Indian Health Service on tribal populations, research planning with NIH, and joint conferences, workshops and planning meetings with HRSA and other agencies.

3.6 Does the program use strong financial management practices?

Answer: YES Question Weight: 11%

Explanation: The program receives clean opinions on its audits and is free of material internal control weaknesses. SAMHSA is participating in a department-wide initiative to implement a new Unified Financial Management System. SAMHSA will in the meantime replace the current DOS-based Integrated Financial Management System with a customized government-off-the-shelf system for tracking commitment and obligation data. The Integrated Resource Management System provides for tracking of commitments and obligations and for numerous management reports.

Evidence: Discussions and documents from agency managers, audited statements from the Program Support Center; Office of the Inspector General reports.

Program Assessment Rating Tool (PART)

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

3.7 Has the program taken meaningful steps to address its management deficiencies? Answer: YES Question Weight: 11%

Explanation: The program is taking meaningful steps to address management deficiencies in key areas. A conversion to a performance partnership grant will increase the amount of information gathered on grantee performance on select outcome measures. The program is addressing accountability for results at both the federal and grantee level. The agency is taking steps to begin retraining federal project officers on a new skill set needed to successfully transform the block grant into a performance partnership grant. The new grant will require states to report on a common set of performance measures and state-specific goals. The agency seeks to work with states under the new arrangement to better target technical assistance and help states improve program performance.

Evidence: SAMHSA is developing a website for a state profile database that will include state-specific information excerpted from the uniform applications for the block grant and two of the agency's national surveys and will eventually be made available to the public. The agency plans to implement performance plans for all staff, which must include at least one element that tracks back to these objectives by September 30, 2003. The agency also plans to ensure program and management objectives in the SAMHSA Administrator's performance contract are incorporated into the performance plans of senior management and staffs. The use of performance measures in employee evaluations is under examination.

3.BF1 Does the program have oversight practices that provide sufficient knowledge of grantee activities? Answer: YES Question Weight: 11%

Explanation: The program does have sufficient oversight capacity. This capacity will improve with respect to outcomes of the block grant with the transition to performance partnerships. However, the program is able to document grantees use of funds in compliance with legislatively designated categories, conducts site visits to a substantial number of grantees on a regular basis and confirms expenditures in annual reports. Through national level relationships and the work of the project officers, the program has a fairly high level of understanding of what grantees do with the resources allocated to them. The agency's State Systems Development Program includes technical reviews of state operations. The reviews examine state systems, quality assurance efforts, and compliance with set-asides and other requirements. Select documentation from states indicate the reviews are also useful from the grantee's perspective.

Evidence: Evidence includes agency documentation, applications and the performance plans and reports. The 1999-2002 technical review project provides details on the 32 of the states. Financial findings include 94 percent of states review financial reports and six percent have annual budget reviews. Quality assurance findings include 91 percent use placement criteria, 28 percent use outcome measures and three percent use performance-based contracts. Three states were not spending at or above the 20 percent prevention set-aside and four more had inadequate data to determine compliance. Other factors include lapsing funds, prohibited expenditures, confidentiality procedures, and management tools (Aggregate Report, 2002).

3.BF2 Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner? Answer: NO Question Weight: 11%

Explanation: Grantee performance data are currently only available to the public at the national level and not disaggregated by state. Annual performance data are aggregated in the performance report and are available to the public through the SAMHSA web site. A conversion to a performance partnership grant will also increase the amount of information gathered on grantee performance on select outcome measures. Each state conducts a public comment forum on the intended use of block grant funds.

Evidence: Assessment based on agency web site (www.samhsa.gov/funding/funding.html). Additional information is available through the National Association of State Alcohol and Drug Abuse Directors (http://www.nasadad.org/).

Program ID: 10001066

Program Assessment Rating Tool (PART)

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

4.1 Has the program demonstrated adequate progress in achieving its long-term performance goals? Answer: NO Question Weight: 25%

Explanation: As noted in Question 2 of the Strategic Planning section, the agency has not yet adopted specific targets and developed a baseline for new long-term outcome goals. The program's existing annual measures are output and do not demonstrate progress toward achieving long-term performance goals. By design, the emphasis for executing the block grant has been to provide states with a flexible source of funds, technical assistance, and minimal interference and burden. As a result, the program has not to date developed an infrastructure to capture outcomes data from grantees.

Evidence: Assessment based on annual GPRA report, SAMHSA-wide performance measures document and draft measures for the performance partnership grant.

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: NO Question Weight: 25%

Explanation: As noted in Question 4 of the Strategic Planning section, the agency has not yet developed a baseline and adopted targets for all the annual goals that support the desired long-term outcomes of the program.

Evidence: Assessment based on annual GPRA report, SAMHSA-wide performance measures document and draft measures for the performance partnership grant.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: SMALL EXTENT Question Weight: 25%

Explanation: The program has recently initiated steps to improve efficiencies but has realized only limited efficiency improvements to date. The program has relied on electronic means of conducting business, including state applications and reports. The agency has also directed additional services to a consolidated Program Support Center. The program has also increased the efficiency of technical assistance efforts by succeeding in having more efforts result in change in systems, programs or practice. In the future, efforts to transition to a performance partnership grant can also improve efficiency in achieving program goals. The agency states that changes to an internet based application next year will also reduce administrative costs. A reengineering effort recently initiated may also improve efficiencies in the future better coordinate technical assistance across various agency programs.

Evidence: The percentage of technical assistance events resulting in changes in state systems, programs or practices increased from 66% in 1999 to 84% in 2000. The agency's efforts to transition to a performance partnership grant are intended to reduce requirements in the block grant through an increase reliance on reporting on outcomes. The new structure should enable the program to more efficiently achieve outcome goals in substance abuse treatment and prevention. SAMHSA has also developed a template for states to determine costs of prevention services as a first step toward determining cost-effectiveness. The agency has not undergone an A-76 competition.

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: NA Question Weight: 0%

Explanation: Numerous Federal funding sources are available to support substance abuse treatment and prevention services. State and local entities also invest resources in this area. However, the block grant is the only federal activity designed specifically to support state-wide services to all states in this area. No comparisons of the effectiveness of treatment services through Medicaid and treatment services supported by the block grant have been conducted.

Evidence: Evidence includes GAO HEHS 00-50, agency budget reports.

Program Assessment Rating Tool (PART)

Program: Substance Abuse Prevention and Treatment Block Grant
Agency: Department of Health and Human Services
Bureau: Substance Abuse and Mental Health Services Administration
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Ineffective
80%	50%	89%	8%	

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?

Answer: NO

Question Weight: 25%

Explanation: The program has not had evaluations meeting the standard for this question that are at the national program level, rather than one or more partners, are comprehensive and focused on the program's impact, effectiveness or other measurement of performance. State technical reviews provide information on the states obligations and expenditures in accordance with the statute, service delivery by modality, quality improvement and opportunities for technical assistance. The agency reviewed 53 state outcome studies that rely on different time intervals, definitions of use, employment, criminal activity and other factors. While definitions and findings vary, the individual studies indicate treatment is effective. However, states are not reporting on common outcome data. OIG conducted a 1997 evaluation of block grant activities in Minnesota. Prevention studies not specific to the block grant conducted by RAND and other researchers have concluded prevention efforts in schools and the community are cost effective and produce savings resulting from reduced tobacco, alcohol and drug use.

Evidence: Source documents include GAO HEHS 00-50, agency GPRA plans and reports, and other agency documentation. GAO found problems with the quality of state data for the implementation of the Synar amendment (GAO 02-74). Treatment effectiveness studies not focused on the block grant include Drug Abuse Treatment Outcomes Study, Services Research Outcomes Study and other research conducted by external organizations. Data from the 1997 National Treatment Improvement Evaluation Study indicate the agency's substance abuse treatment competitive demonstration grants were effective, but no evaluations have been conducted specific to block grant funded activities. The 1997 OIG report found the state agency administered the grant effectively but did not always require grantees to establish program goals for measurable outcomes and lacked a fully compliant independent peer review process.

PART Performance Measurements

Program: Substance Abuse Prevention and Treatment Block Grant

Agency: Department of Health and Human Services

Bureau: Substance Abuse and Mental Health Services Administration

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Measure: Number of persons served (treatment)

Additional Information: The current calculation is based on dollars spent divided by a national cost estimate. SAMHSA will negotiate new data reporting through the performance partnership grant.

Year	Target	Actual
2000		999,813
2002	1,021,845	
2003	1,042,281	
2004	1,063,126	
2005	1,084,389	

Measure Term: Annual

OMB Program Assessment Rating Tool (PART)

Competitive Grant Programs

Name of Program: Substance Abuse Treatment Programs of Regional and National Significance

Section I: Program Purpose & Design (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	No	The purpose of the drug treatment Programs of Regional and National Significance discretionary program cannot be stated succinctly. The mission of the program is to improve the quality and availability of drug treatment services. The program includes drug treatment service grants on one side, which have a clear purpose and design, and training, communications and regulatory activities on the other, which are less clear. Conceptually, the two main elements combine as supporting drug treatment services and improving the quality of those services. Actual coordination between the two sides is unclear, and the unifying purpose for this discretionary budget is unclear. The agency is refocusing its mission on supporting services and is developing a strategic plan, both of which will add clarity to the program purpose.	The FY 2003 budget of $358 million is divided up by roughly 17 different grant streams. The agency is working to refocus the program on delivering services, but the purpose is not yet clear. The program is run by the Substance Abuse and Mental Health Services Administration (SAMHSA).	20%	0.0
2	*Does the program address a specific interest, problem or need?*	Yes	The program is designed to address the need for effective drug treatment services, especially in hard hit communities and for target populations. Service grants help areas with critical or newly emerging problems. Training, communications and regulatory grants are designed to improve treatment outcomes. Grantee data indicate those served by the program's drug treatment grants are more likely to be female and more likely to be minorities than national treatment averages (49% v 27% and 52% v 28%, respectively).	The 2001 National Household Survey on Drug Abuse (NHSDA) estimates 16 million Americans used an illicit drug in the past month, 6.1 million persons above age 12 need treatment, 5.0 million need treatment but are not getting it, and 4.6 million people who meet the criteria for needing treatment do not even recognize that they need treatment.	20%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Is the program designed to have a significant impact in addressing the interest, problem or need?*	Yes	The program is the Federal government's primary mechanism to target key areas and populations with support for drug treatment services. While the program is a relatively small portion of all public drug treatment funding, it is designed to have a significant impact that is reasonably known and can be measured in the context of all other factors. Drug treatment is designed to reduce drug use and its consequences. Outcome data from the program are available and the impact is known. The services grants provide meaningful assistance in individual hard hit communities receiving an award. The program's services grants also require scientifically established practices, which is important to improve drug treatment outcomes. State/local governments also support drug treatment clinics. The reach of the training efforts is limited relative to the number of drug treatment service providers and the extent to which many of those providers are using unproven methods. None of the grants leverage financial resources.	Effective drug treatment is designed to have a significant impact on reducing drug use. The program supported an estimated 100,000 drug treatment admissions in 2002. According to agency estimates, drug treatment supported by the program in 2001 constitutes roughly 10% of Federal support and 5% of all public support for drug treatment.	20%	0.2
4	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	The program makes a unique contribution. Service grants are designed specifically to fill gaps. While state and local governments support drug treatment, neither focus on regional, emerging problems. While schools and accreditation bodies play a role in improving the quality of treatment services, the program's training, communications and certification efforts are also unique. The agency also supports a substance abuse block grant, which provides even support to states to support alcohol and drug abuse prevention and treatment. The program shares many of the same goals as the block grant, but is designed for a different purpose.	The Drug Abuse Warning Network and other surveys show pockets across the country with critical problems, or new problems such as ecstasy or methamphetamine use.	20%	0.2
5	*Is the program optimally designed to address the interest, problem or need?*	Yes	The program accomplishes its goals primarily through competitive grants. The program includes competitive drug treatment services grants to non-profit organizations and local and tribal governments to address gaps in treatment capacity, grants to community-based organizations to provide coordinated substance abuse and HIV services, grants to academic institutions to provide training for drug treatment providers, and grants to entities to support networking and technology transfer to accelerate the process of putting new drug treatment knowledge into practice.	There is no evidence that block grants, regulations, or other approaches would be more effective or efficient to accomplish program goals.	20%	0.2
Total Section Score					**100%**	**80%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning		**(Yes, No, N/A)**				
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	The program has adopted long-term outcome goals through the assessment process. The outcome goals also relate to national outcome goals of the Office of National Drug Control Policy.	The program's long-term goals include the effectiveness of drug treatment services as measured by reductions in drug use six months after the conclusion of treatment, changes in the efficiency of grantees as measured by the percentage of providers that do not exceed approved costs per person treated according to the type of treatment provided, and the effectiveness of program training efforts as measured by the percentage of drug treatment providers that report adopting approved treatment methods as a result of receiving training and best practices information from the program.	14%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	Agency has a limited number of valid annual performance goals focused on outcomes that demonstrate progress toward achieving desired long-term outcomes. The program's annual goals also relate to Office of National Drug Control Policy long-term goals.	Annual goals include the reductions in past month use, improvements in program efficiency, and changes in treatment methods resulting from program training efforts.	14%	0.1
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	Individual service grantees provide performance data through a common software system to measure annual goals. Further steps to use data to reward performance could encourage additional buy-in to program goals. Training partners also provide performance information. In a more general sense, the treatment community embraced the program's mission through the development of a National Treatment Plan.	Service grantees input performance information into an ACCESS database. Data is compiled to report progress on annual goals. Grantees report on drug use, employment and other outcomes using a Core Client Outcomes tool.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	Meaningful collaboration with other Federal agencies that share similar objectives has increased, especially with the Department of Justice, the Office of National Drug Control Policy, and within HHS. Most significantly, SAMHSA has begun to collaborate more fully with the National Institutes of Health to improve the translation of science to services and refocus SAMHSA on service delivery. In order to be successful, this effort will require a further development of meaningful collaboration, including the full involvement of NIH to provide research findings to SAMHSA in a useful way and incorporate lessons gathered from SAMHSA's drug treatment services grantees into its research agenda. In 2002, SAMHSA is also supporting drug treatment services in criminal justice in collaboration with the Department of Justice. Representatives from VA, the Health Resources and Services Administration, and the Bureau of Prisons also participated in deliberations for the program's treatment plan. A 1997 GAO report found a dearth of collaboration, and not all of these areas have been addressed.	GAO reported that SAMHSA needs to improve its coordination with agencies engaged in similar or complementary activities. The report suggested for example the need to improve work with Justice, Veterans Affairs, Education, Indian Health Service and the National Institutes of Health.	14%	0.1
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	In 1997, the University of Chicago and Research Triangle Institute concluded the National Treatment Improvement Evaluation Study (NTIES). The purpose of the study was to demonstrate the value of the comprehensive treatment model supported by the program. The study considered how funds were used, what were the results of comprehensive treatment, and what lessons have been learned about cost and implementation. Data collection for the study ended in 1995 and since that time, there have been no comprehensive evaluations of the program. The program has studied the impact of specific treatment approaches through its Methamphetamine Treatment Project. No independent and comprehensive evaluations of the program's training and knowledge dissemination activities have been conducted.	The NTIES evaluation was a comprehensive assessment of 157 multi-year awards across 47 states and several territorial areas made from 1989–1992. In addition to the NTIES study, SAMHSA reports directing extensive grantee efforts for evaluation, however, these reviews are not compiled into an independent and comprehensive assessment.	14%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	The program cannot estimate the associated cost of each drug treatment service supported by the program, which is the main output directly associated with the program's outcome goals. Annual budget requests are not clearly derived by estimating what is needed to accomplish the annual performance measures and long-term outcomes. The program budget structure varies from program goals and the impact of funding decisions for the budget line on the actual performance of the program overall as a collection of its individual components is difficult to predict. The program can cost out anticipated outcomes by funding level based on average national cost of treatment. However, beyond using national averages, the program cannot measure the impact of proposed funds on program performance and outcomes.	Assessment based on annual budget submissions to OMB and Congress.	14%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	The main deficiencies highlighted in this section are the need for long-term outcome measures, continued evaluations of the program, and improved alignment of budget and goals so that the impact of funding and policy changes on performance is readily known. The agency is also going through a strategic planning process and has adopted draft long-term outcome goals. Having these measures in place will also enable the program to better integrate budget planning and strategic planning and determine the level of financial resources needed to obtain long-term outcomes. The National Treatment Outcome Monitoring System (NTOMS) to be implemented in 2003 will provide new outcome data to fill gaps in performance information.	Assessment based on discussion with agency and the program management plan. The agency is awarding a contract for NTOMS this year. The program plans evaluations of the effects of opiate treatment programs when buprenorphine is approved by the Food and Drug Administration. The agency's restructuring plan consolidated budget formulation, planning and Government Performance and Results Act activities within one unit.	14%	0.1
Total Section Score					**100%**	**86%**

Section III: Program Management (Yes, No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	No	Data are not regularly used by managers in management and budget decisions. Annual performance data are collected, checked for validity and used to some extent by project officers. Explanations are offered when targets are not met, but significant changes have not been made to improve performance. Managers report being unable to use past performance as a factor in grantee competitions.	Managers do not regularly use outcome data. For example, when lower than expected program outputs were discovered from grantee reports, no steps were taken to revise the program, shift resources, or improve grantee performance.	9%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Are Federal managers and program partners (grantees, sub grantees, contractors, etc.) held accountable for cost, schedule and performance results?*	No	Neither managers nor partners are held directly accountable for program outcomes. Performance data are not used in employee evaluations. Grantees compete for funds initially, but only lose funding for poor performance in extreme cases. The agency is planning a significant change in grant management described below that will enhance partner accountability.	Assessment is based on public personnel documents, discussions with the agency and grant announcements and reports. The agency has also taken new steps to identify and target the roughly 10% of program grantees that are not reporting outcomes data. Following contacts first by project officers and then by an agency contractor, the agency reports a significant reduction in non-reporting.	9%	0.0
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	Funds are obligated efficiently and in accordance with planned schedules. The agency is working to release some grants earlier in the fiscal year. There have been very few known cases of funds being expended outside of their intended purpose. Project officers perform site reviews when possible.	Assessment based on apportionment requests; annual budget submissions and financial reports, queries in Single Audit Database and agency grants management procedures. For reference, project officers visit roughly 25% of grantees annually.	9%	0.1
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	In general, there is insufficient evidence that the program has incentives and procedures in place to improve efficiency and cost effectiveness in program execution to meet the standards for this question. The program is working to include an efficiency measure. The agency does rely on an HHS service clearinghouse known as the Program Support Center for many internal services, is providing FAIR Act targets, and appears to be making progress toward outsourcing additional services. Outsourced activities include accounting, graphics, human resources, and property management. The program also has automated the process for entering performance outcome data.	FAIR Act report, services directed to HHS' consolidated Program Support Center.	9%	0.0
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program does not have a financial management system that fully allocates program costs and associates those costs with specific performance measures. The program develops annual budget proposals that include associated FTE and accrual costs. However, the program is unable to cost out resources needed to achieve targets and results. The program does not capture all direct and indirect costs borne by the program agency, including applicable agency overhead, retirement, and other costs budgeted elsewhere, or include informational displays in the budget that present the full cost of outputs. FTE and administrative expenses are not tied to annual program budgets.	Assessment based on annual program management budget requests and discussions with agency.	9%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
6	*Does the program use strong financial management practices?*	Yes	The program receives clean opinions on its audits and is free of material internal control weaknesses. The agency's fiscal monitoring of grant awards is conducted through the SAMHSA Grants Information Management System, which tracks awards and obligations, carry over and submission of quarterly reports, application renewals and final reports. The system is used to flag grantee financial management issues for project officers and Federal managers.	The assessment is based on audited statements from the Program Support Center and Office of the Inspector General reports.	9%	0.1
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	The main deficiencies include use of performance data to enhance accountability, the ability to identify changes in performance with changes in funding levels, and additional incentives and procedures to improve efficiency. Most significantly, the agency reports taking additional steps to introduce funding incentives and reductions to improve grantee performance. This reallocation of second and third year awards would provide a powerful incentive to improve accountability and ultimately grantee efficiency and performance for drug treatment service grants. The agency has also begun placing grantees that fail to report performance data to the agency in a risk pool that will require weekly contact with project officers until data submission is complete and is exploring additional sanctions. The agency is extending its performance contracts to increase accountability and reports taking additional steps to hold staff accountable for program performance. The agency is also reorganizing the Center to more effectively use FTE resources at the Federal level.	The assessment is based on conversations with the agency, management plan documents, and Federal Register notices. The agency's restructuring plan consolidated budget formulation, planning and Government Performance and Results Act activities within one unit. Steps to improve efficiency include reductions in deputy manager positions and consolidation of smaller offices.	9%	0.1
8 (Co 1.)	*Are grant applications independently reviewed based on clear criteria (rather than earmarked) and are awards made based on results of the peer review process?*	Yes	Applications for this program are peer reviewed based on clear criteria and awards are made based on merit as judged through the peer review process. A central office within the agency organizes and conducts independent review of grant applications for agency programs. There are some one-year, non-competitive earmarks, but the majority of funds are competitively awarded.	Assessment based on grant review procedures, Federal Register Notices.	9%	0.1
9 (Co 2.)	*Does the grant competition encourage the participation of new/first-time grantees through a fair and open application process?*	Yes	The grant competition is open to new/first-time grantees. The agency has also hosted sessions for faith and community based organizations to encourage them to apply and provide technical assistance.	Assessment based on technical assistance documents and planning sessions for faith and community based organizations.	9%	0.1
10 (Co 3.)	*Does the program have oversight practices that provide sufficient knowledge of grantee activities?*	Yes	Agency staff serve as project officers for grantees and meet with providers at conferences and other settings. Grantees report annually on performance and the agency is taking steps to improve data reporting.	Assessment based on grantee reports. See also Question 4 explanation and evidence.	9%	0.1

Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
11 (Co 4.) *Does the program collect performance data on an annual basis and make it available to the public in a transparent and meaningful manner?*	Yes	Grantees enter data in a shared database. Annual performance data are summarized in the performance report and made available on the agency web site. Additional steps can be taken to make performance data at the state level publicly available, especially with the expansion of a targeted capacity expansion grant to states.	Assessment based on agency GPRA reports and web site (www.samhsa.gov).	9%	0.1
Total Section Score				**100%**	**64%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section IV: Program Results		**(Yes, Large Extent, Small Extent, No)**				
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Small Extent	The agency has adopted new long-term outcome goals. Two of the goals are new and baseline data are estimates. The first measure will track the effectiveness of drug treatment services by measuring reductions in drug use six months after admission to treatment. The second goal will capture changes in grantee efficiency by measuring the percentage of providers that do not exceed approved costs per person treated according to the type of treatment provided. Approved costs will be determined separately for outpatient, inpatient and methadone treatment using national averages and data on demographics of patients treated. This measure will also be used by program managers in reviewing applications and renewals, such as by not funding applicants whose proposed budgets are outside the range of acceptable costs. The third goal tracks the portion of drug treatment providers that report adopting approved treatment methods as a result of receiving training and best practices information from the program. A large extent would require progress on more than one measure.	The National Treatment Outcomes Monitoring Study (NTOMS) will be used to determine the success rates of drug treatment supported by the program. In addition to providing a national comparison, NTOMS will allow the program to add sampling frames specific to grantees to cover external evaluation and allow grantees to dedicate more funding to services. The efficiency goal of acceptable costs is based on data from the Alcohol and Drug Services Study (ADSS). Cost comparisons will be made by modality, including inpatient, outpatient and methadone treatment. ADSS costs are per person per episode while the ranges used by the program are per person over a specified time period. The current baseline for this measure is an estimate of grantee performance. The agency has proposed an acceptable range of costs to mean $3,000 to $10,000 for residential treatment, $1,000 to $5,000 for outpatient non-methadone, and $1,500 to $8,000 for methadone. These ranges are under review. Targets for the third measure may also need to be adjusted when baseline data are confirmed.	20%	0.1

Long-Term Goal I:	Increase the percentage of individuals who have received drug treatment services that show no past month substance use six months after admission to treatment. (new measure)
Target:	42% by 2006
Actual Progress achieved toward goal:	36% in 2002, 34% in 2001; 30% in 2000 (at time of discharge from treatment -- or roughly three months after admission to treatment; baseline under development)
Long-Term Goal II:	Increase the percentage of grantees that provide drug treatment services within approved cost per person guidelines by the type of treatment, such as
Target:	76% by 2006
Actual Progress achieved toward goal:	60% in 2000 (estimate, approved cost range, target and baseline under development)
Long-Term Goal III:	Increase the percentage of drug treatment professionals trained by the program that report the adopting approved treatment methods as a result of receiving training and best practices information from the program. (new measure)
Target:	48% of those trained
Actual Progress achieved toward goal:	40% in 2001 (estimate, data to be provided January 2003. Target and baseline under development)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program (including program partners) achieve its annual performance goals?*	Small Extent	The program has some relevant data for the first new annual measure. The new measure tracks impact of treatment six months after admission to treatment. Drug use data are currently available from grantees at the time of discharge from treatment only. However, the program is meeting the targets for reduced use at the time of discharge from treatment consistent with their old measure. Not all program activities are currently being captured in this measure and data are not yet available for the other two measures. A large extent would require a more complete documentation of progress on more than one measure.	Evidence is collected through grantee reports and presented in the agency's annual GPRA report.	20%	0.1

Key Goal I:	Increase the percentage of individuals who have received drug treatment services that show no past month substance use six months after
Performance Target:	35% in 2002 (at time of discharge from treatment)
Actual Performance:	02; 34% in 2001; 30% in 2000 (at time of discharge from treatment -- or roughly three months after admission to treatment; baseline under deve
Key Goal II:	Increase the percentage of grantees that provide drug treatment services within approved cost per person guidelines by treatment modality
Performance Target:	68% in 2004
Actual Performance:	60% in 2000 (estimate, approved cost range, target and baseline under development)
Key Goal III:	Increase the percentage of drug treatment professionals trained by the program that report implementing improvements in treatment methods on the basis of information and training provided by the program. (new measure)
Performance Target:	44% in 2004
Actual Performance:	40% in 2001 (estimate, data to be provided January 2003. Target and baseline under development)

3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	No	The agency is not meeting the standards of a Yes for having incentives and procedures to measure and achieve efficiencies. Program targets for increasing the drug treatment service capacity have not been met and have been revised down in subsequent years. Even if the prior year data were flawed, there are no new data available to indicate improvements in program efficiencies and cost effectiveness over the previous year. There are no data on improved efficiencies for training, communications or regulatory/certification efforts.	Funding for drug treatment services grew from 2000 to 2001, but the program adjusted down its annual targets for the number of people served from 23,000 to 14,000 based on lower than expected performance in the prior year. The revised figures are attributed to improvements in data collection and verification efforts, however, no new data on improved program efficiencies are available.	20%	0.0

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	Large Extent	The program is the only competitive program of its kind that supports drug treatment for the general population outside of the criminal justice system. However, the program may be a more cost efficient and effective mechanism to focus specifically on drug treatment than the substance abuse block grant, which also support alcohol treatment and primary prevention services. The program tracks annual performance data on reductions in past month substance use and other treatment outcomes that indicate performance. Similar data on performance are not available for the block grant. Grantees also seem to perform as well or better than grantees funded by state and local governments or other sources. There are no data on how well the training, communications and regulatory/certification efforts compare with other efforts.	There are no definitive data on what portion of the Substance Abuse Block Grant supports drug treatment, complicating estimates of the impact of a funding increment on drug treatment services. The agency has previously calculated that supporting a drug treatment slot through the program costs 1/3 less than through the block grant, however, these calculations are based on estimates rather than actual cost of treatment and may be revised. With respect to performance information, the efforts are underway to track outcome data for the block grant, but no effectiveness data are available at this time. By comparison, annual outcome data collected by this program indicates an impact on reducing past month drug use by 34% of those treated and the negative consequences of use such as reduced or no involvement with the criminal justice system by 75% of those treated. Grantee data indicate those treated by the program are more likely to be female and more likely to be minorities than national treatment averages (49% v 27% and 52% v 28%, respectively).	20%	0.1
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Small Extent	Data from the 1997 National Treatment Improvement Evaluation Study indicate the program's substance abuse treatment demonstration grants were effective. While the evaluation found drug treatment grants were effective, the agency has not had a comprehensive evaluation of their training and regulatory/certification efforts, or the drug treatment Programs of Regional and National Significance activity as a whole.	Key findings from the NTIES include clients' use of their primary drug(s) declined from 73% to 38% one year after treatment; selling drugs declined by 78%; arrests for any crime declined 64%; rate of employment increased from 51% to 60% following treatment; and alcohol/drug-related medical visits declined 53% following treatment. Outpatient methadone treatment costs were about $3,900 for an average of 300 days of treatment, outpatient non-methadone treatment costs were about $1,800 for an average of 120 days, and treatment in a correctional setting cost $1,800 for an average of 75 days. With respect to the program's knowledge dissemination efforts, the OIG found in 1998 that only 32% of SAMHSA's own grantees are aware of treatment improvement protocols issued by the agency.	20%	0.1
Total Section Score					**100%**	**33%**

OMB Program Assessment Rating Tool (PART)

Research & Development Programs

Name of Program: Translating Research into Practice

Section I: Program Purpose & Design (Yes,No, N/A)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Is the program purpose clear?*	Yes	The Translating Research Into Practice (TRIP) program was established in 1999. The AHRQ reauthorization directs that "to address the full continuum of care and outcomes research, to link research to practice improvement, and to speed the dissemination of research findings to community practice settings, the Agency shall employ research strategies and mechanisms that will link research directly with clinical practice ...". TRIP is AHRQ's overarching strategy for sponsoring applied research to develop sustainable and replicable models and tools to improve health care and widely disseminate the results. The Requests for Applications (RFA) state the purpose of TRIP as bridging the understanding between new scientific knowledge and improved patient care by 1) conducting demonstration projects that focus on evaluating strategies to help accelerate the impact of research on clinical practice and 2) demonstrating that *c*hanges in provider behavior leads to measurable and sustainable health care improvements.	1) Reauthorized 2000-2005 (P.L. 106-129) under the Healthcare Research and Quality Act, which amends Title IX of the Public Health Service Act (http://www.ahrq.gov/hrqa99.pdf). 2) January 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-99-003.html). 3) December 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-00-008.html). 4) May 2002 Partners for Quality Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-02-010.html).	17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
2	*Does the program address a specific interest, problem or need?*	Yes	Every day new reports/studies are released expressing the findings of the latest research. Sometimes these releases are contradictory. How do we determine which studies' findings should be tested and replicated? TRIP assists with that effort. TRIP is a partnership between health care systems/organizations and researchers. Grantees assess the effectiveness of promising new interventions; compare the interventions' benefits, costs, and effects on existing approaches; and provide a unique focus on the interaction between patients and their caregivers. When effective interventions are not being used by health care organizations, this research can identify options for overcoming barriers to their widespread use. The RFAs request applicants to focus on at least one of the following six health conditions: infant mortality, cancer screening, cardiovascular disease, diabetes, HIV/AIDS, and child and adult immunizations, and also mental health and pediatric asthma.	1) January 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-99-003.html). 2) December 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-00-008.html).	17%	0.2
3	*Is the program designed to make a unique contribution in addressing the interest, problem or need (i.e., not needlessly redundant of any other Federal, state, local or private efforts)?*	Yes	Although others also conduct health care research, AHRQ addresses a different part of the health research agenda. NIH research is conducted in laboratories in which scientists identify the biological mechanisms of disease and through clinical trials that establish the potential usefulness of new interventions under ideal conditions. AHRQ's research draws upon data on routine patient care and the performance of the health care system to provide insights on what works, at what cost, and whether purchasers are getting value and quality for their health care dollar. AHRQ moves from the lab to everyday occurrences in and experiences with the health care system.		17%	0.2

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Is the program optimally designed to address the interest, problem or need?*	Yes	TRIP is divided into two parts: grants/contracts and dissemination of information. TRIP grants are designed to build from previous grants and to help move from funding research demonstrations to clinical practice changes by providers. Grantees assess health care systems and organizations' quality improvement strategies. This knowledge is being used to apply and evaluate methods used to develop models of change that are replicable across health care systems and organizations. Also, AHRQ will disseminate TRIP research results in a "Toolbox" via CD Rom for implementation so that other individuals and organizations can adapt methods and instruments for their own implementation. A web-based "Toolbox" is under development, with an expected launch in July 2003. The flow chart for the site has already been developed.	1) January 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-99-003.html). 2) December 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-00-008.html). 3) Toolbox Flow Chart.	17%	0.2
5 (RD 1)	*Does the program effectively articulate potential public benefits?*	Yes	The public request for RFAs and the 2000 Institute of Medicine report regarding the status of the health care delivery system express the importance of going beyond research and beginning to implement replicable, proven practices. Through the TRIP, the findings of research conducted by AHRQ staff and grantees are being used to change provider behavior and to translate improvements in clinical care and the delivery of health care.	1) January 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-99-003.html). 2) December 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-00-008.html). 3) Institute of Medicine, "*Crossing the Quality Chasm".*	17%	0.2
6 (RD 2)	*If an industry-related problem, can the program explain how the market fails to motivate private investment?*	Yes	Private organizations, individual hospitals, providers, and others have limited incentive to take on numerous pilots or other efforts to test proven practices and to make them replicable across the nation. Most entities are performing their own assessments or needed improvements in the management and delivery of care, but these changes are often directed to the deficiencies within their facility/system of care.		17%	0.2
Total Section Score					**100%**	**100%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section II: Strategic Planning (Yes,No, N/A)						
1	*Does the program have a limited number of specific, ambitious long-term performance goals that focus on outcomes and meaningfully reflect the purpose of the program?*	Yes	OMB and AHRQ recently developed ambitious long-term outcome goals that link to the mission of the program.	The following are some of the long-term goals to be achieved by 2010: 1) Reduction in the hospitalization rates for pediatric asthma by persons under the age of 18 years to 105,613 admissions, 2) Reduction in the number of immunizations-preventable pneumonia hospital admissions of persons aged 65 years and older to 520,441 admissions, and 3) Reduction in the number of immunizations-preventable influenza hospital admissions of persons aged 65 years and older to 11,570 admissions.	13%	0.1
2	*Does the program have a limited number of annual performance goals that demonstrate progress toward achieving the long-term goals?*	Yes	In September 2001, AHRQ and OMB agreed to long-term goals for improving the outcomes of health care through the TRIP. These long-term goals have been modified slightly to be annual measures in the FY 2004 Budget.	The following annual goals have been developed for FY 2004: 1) Reduce by 5 percent below the baseline the rate of hospitalizations for pediatric asthma in persons under age 18, 2) Reduce by 5 percent below the baseline the number of admissions for immunization-preventable pneumonia for persons aged 65 or older, 3) Reduce by 5 percent below the baseline the number of admissions for immunization-preventable influenza for persons aged 65 or older, and 4) Reduce by 5 percent below the baseline the number of premature babies who develop Respiratory Distress Syndrome.	13%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Do all partners (grantees, sub-grantees, contractors, etc.) support program planning efforts by committing to the annual and/or long-term goals of the program?*	Yes	RFAs are written to include performance standards directed towards meeting annual program goals and a continuous reporting process. The RFAs stipulate that "[a]pplicants must develop a plan for measuring changes in care patterns at a national level as a result of the dissemination/replication strategy." Also, "[d]ocumentation of results must include benefits to patients and also costs and benefits to individual providers." The long-term and modified annual goals referenced in #1 and #2 will be included in the FY 2004 Annual GPRA Plan.	1) January 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-99-003.html). 2) December 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-00-008.html). 3) May 2002 Partners for Quality Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-02-010.html). 4) FY 2004 Congressional Justification - Annual GPRA Plan.	13%	0.1
4	*Does the program collaborate and coordinate effectively with related programs that share similar goals and objectives?*	Yes	AHRQ is authorized to enter into cooperative agreements with for-profit organizations, public, and not-for-profit entities. AHRQ has partnered with these entities to disseminate findings, tools, and evidence to those who can put it into practice. Also, AHRQ has developed a number of partnerships including serving as the operating chair of the Quality Interagency Coordination Task Force (QuIC) and as an active participant in the HHS Research Coordinating Council. AHRQ has a joint program announcement with the VA for TRIP-related activities. The program announcement (PA) is a collaborative effort that reflects the agencies' similar goals and objectives of translation and implementation. The PA was co-sponsored by the National Institute of Mental Health, the National Cancer Institute, and the National Institute of Alcohol, Abuse, and Alcoholism within NIH. NIH and AHRQ often coordinate on funding proposals to eliminate duplication among the parts of a research effort.	1) QuIC Fact Sheet. 2) Joint program announcement with the VA.	13%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
5	*Are independent and quality evaluations of sufficient scope conducted on a regular basis or as needed to fill gaps in performance information to support program improvements and evaluate effectiveness?*	Yes	TRIP grants were first funded in FY 2000 (three-year grants). The Research Triangle Institute has conducted a formative evaluation of TRIP grants that focused on the efficacy of the program. The study also formed the evaluation questions for a comprehensive program evaluation to be conducted in FY 2005, pending the completion of funding for the second round of TRIP grants in FY 2003 and having the necessary resources.	RTI - Project No 06703-007.	13%	0.1
6	*Is the program budget aligned with the program goals in such a way that the impact of funding, policy, and legislative changes on performance is readily known?*	No	AHRQ's OMB budget justification and Congressional justification display the AHRQ budget. However, when AHRQ submits its budget request to the Department for review, the annual targets are adjusted according to the funding level requested and/or the final funding level provided by the Department. Budget requests and funding level decisions are not made based on achieving the established long-term and annual performance goals.	1) OMB Budget Justification submitted each Fall. 2) Congressional Justification submitted each February with the President's Budget.	13%	0.0
7	*Has the program taken meaningful steps to address its strategic planning deficiencies?*	Yes	The complete TRIP portfolio is planned to undergo an external review in FY 2005. In addition, AHRQ has acknowledged the multiple difficulties of tracking budgetary expenditures along with tying these expenditures to actual program performance. AHRQ plans, using budgeted FY 2003 resources, to begin to deploy a reporting module (phase I) to the activity areas allowing them to view and track their own budgets. Phase II will allow the activity areas to interconnect appropriate areas of the Agency's planning system with the budget system through a set of common fields, and finally, the GPRA program goals. The ultimate goal of this project will be targeted integration of the existing Agency planning database with the budget database system, allowing Agency leadership to easily identify, and flag for action those program areas that are not meeting their GPRA goals.		13%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
8 (RD 1)	*Is evaluation of the program's continuing relevance to mission, fields of science, and other "customer" needs conducted on a regular basis?*	NA	A regular evaluation of the program's mission and customer needs is not conducted, as this is a new program. These grants were first funded in FY 2000. Formal evaluation of the program mission is not yet underway; however, AHRQ conducts outreach to its grantees to try to determine the impact of this program.		0%	
9 (RD 2)	*Has the program identified clear priorities?*	Yes	TRIP focuses on three priorities: 1) funding new research on priority health issues, 2) providing resources that grantees may develop tools, and 3) assisting with identifying areas where providers/institutions may move the research into practice in clinical settings.	1) January 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-99-003.html). 2) December 1999 TRIP Request for Applications (http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-00-008.html).	13%	0.1
Total Section Score					**100%**	**88%**

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
Section III: Program Management (Yes,No, N/A)						
1	*Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?*	No	AHRQ has only recently begun to focus on measuring the results of the program. The Agency collects data as part of its annual Planning and Program Development review and program award and research efforts are reported annually in the AHRQ Congressional Justification. However, AHRQ does not use this information to manage the program, such as (re)allocating resources to high performing/efficient/effective programs.	Work plan tasks and subtasks.	11%	0.0
2	*Are Federal managers and program partners (grantees, subgrantees, contractors, etc.) held accountable for cost, schedule and performance results?*	Yes	The Agency's strategic plan guides the overall management of the agency. Each Office and Center has an individual strategic plan and annual operating plan. Cost, schedule, and performance are part of the performance plans of the AHRQ management, including Division, Center, and Agency Directors. Contracts are performance-based. The annual operating plan identifies those things that contribute to AHRQ achieving its performance goals and internal management goals. These factors are incorporated into each employee's annual performance plan/review. At the end of each year, the Office and Center Directors review accomplishments in relation to the annual operating plans in preparation for drafting the next year's plans. The results of these reviews contribute significantly to Office and Center performance reports. Some managers' performance plans also take into consideration their staffs performance in managing program operation.	Program managers' performance contract.	11%	0.1
3	*Are all funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?*	Yes	All appropriated funds are obligated in accordance with the annual operating plans, formulated for obligation and outlays on a quarterly basis.	1) Estimated obligations by quarter in apportionments for FYs 1999-2002. 2) Actual obligations by quarter for FYs 1999-2002.	11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
4	*Does the program have incentives and procedures (e.g., competitive sourcing/cost comparisons, IT improvements) to measure and achieve efficiencies and cost effectiveness in program execution?*	No	The program's operating plans do not include efficiency and cost effectiveness measures, and targets such as per unit cost or some other measures directly linked to the activities of the program.	2002 Operating Plan Goals.	11%	0.0
5	*Does the agency estimate and budget for the full annual costs of operating the program (including all administrative costs and allocated overhead) so that program performance changes are identified with changes in funding levels?*	No	The program's annual budget requests are not derived in such a way that full annual costs associated with achieving annual goals are included in the submission, either formally or informally. AHRQ, like most other agencies across government, develops its budget using the reverse methodology. They identify the funding level, then increase or decrease their annual targets according to the funding level proposed.	1) OMB Budget Justification. 2) Congressional Justification.	11%	0.0
6	*Does the program use strong financial management practices?*	NA	Because the Department prepares audited financial statements for its largest components only, AHRQ financial statements are not audited. In 2002, AHRQ has engaged Clifton Gunderson LLP for technical support consultation and analysis of certain financial management practices.		0%	
7	*Has the program taken meaningful steps to address its management deficiencies?*	Yes	AHRQ is adopting performance-based contracts for TRIP activities, which require superior performance by the contractor to receive the full project fee. This will help staff to manage the program based on improved performance. Other contracts are awarded on a competitive basis or sole sourced to capable entities with proven results.		11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
8 (RD 1)	*Does the program allocate funds through a competitive, merit-based process, or, if not, does it justify funding methods and document how quality is maintained?*	Yes	AHRQ announces research grant opportunities through program announcements and requests for applications. Contract opportunities are announced through a similar process. Grant applications are reviewed for scientific and technical merit by a peer review group with appropriate expertise. Funding decisions are based on the quality of the proposed project, availability of funds, and program balance among research areas. Contracts are awarded using a similar process.		11%	0.1
9 (RD 2)	*Does competition encourage the participation of new/first-time performers through a fair and open application process?*	Yes	HHS' policies create a fair and open competition including making project documents and products available for review by new bidders. Also, the PAs and RFAs encourage the development of new ideas and research questions		11%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
10 (RD 3)	*Does the program adequately define appropriate termination points and other decision points?*	No	The scope of this question extends beyond a grantee receiving an award and the respective grant cycle. Given the program purpose and design, which focuses on partnerships that help move research into changes in the health care delivery system, it is unclear when program staff and policy makers can determine that TRIP has been successful. It is difficult to determine how/when the program should end. How do we measure success in the health care system? Is it that as long as long-term and annual goals are being met the program is successful? Is it once numerous methods have been replicated at every hospital across the nation?		11%	0.0
11 (RD 4)	*If the program includes technology development or construction or operation of a facility, does the program clearly define deliverables and required capability/performance characteristics and appropriate, credible cost and schedule goals?*	NA			0%	
Total Section Score					**100%**	**56%**

Section IV: Program Results (Yes, Large Extent, Small Extent, No)

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
1	*Has the program demonstrated adequate progress in achieving its long-term outcome goal(s)?*	Small Extent	AHRQ-funded research has contributed to the overall decline in the national number of immunization- preventable admissions in adults age 65 and older for pneumonia or influenza, rate of hospitalization for pediatric asthma, number of premature babies who develop Respiratory Distress Syndrome. AHRQ collects much of these data, but not systematically and not for reporting. AHRQ will begin reporting on these new long-term, outcome-oriented GPRA measures, beginning with the FY 2004 Budget request.		25%	0.1

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
	Long-Term Goal I: Reduce to 105,613 admissions, the rate of hospitalizations for pediatric asthma in persons under age 18.					
	Target:	105,613 admissions by 2010.				
	Actual Progress achieved toward goal:	150,876 in 2000; 178,901 in 1999.				
	Long-Term Goal II: Reduce to 520,441 the number of immunization-preventable pneumonia hospital admissions of persons aged 65 and older.					
	Target:	520,441 admissions by 2010.				
	Actual Progress achieved toward goal:	743,487 in 2000; 792,264 in 1999.				
	Long-Term Goal III: Reduce to 11,570 the number of immunization-preventable influenza hospital admissions of persons aged 65 and older.					
	Target:	11,570 admissions by 2010.				
	Actual Progress achieved toward goal:	16,529 in 2000; 17,508 in 1999.				
	Long-Term Goal IV: Reduce to 500 per 100,000 live births the number of premature babies who develop Respiratory Distress Syndrome (RDS).					
	Target:	Target to be determined.				
	Actual Progress achieved toward goal:	Baseline to be determined.				
2	*Does the program (including program partners) achieve its annual performance goals?*	Small Extent	AHRQ-funded research has contributed to the overall decline in the national number of immunization- preventable admissions in adults age 65 and older for pneumonia or influenza, rate of hospitalization for pediatric asthma, number of premature babies who develop Respiratory Distress Syndrome. AHRQ will begin reporting on these new and modified annual GPRA measures, beginning with the FY 2004 Budget request.		25%	0.1
	Key Goal I: Reduce by 5 percent below the baseline the rate of hospitalizations for pediatric asthma in persons under age 18.					
	Performance Target:	5 percent below baseline annually.				
	Actual Performance:	150,876 in 2000; 178,901 in 1999.				
	Key Goal II: Reduce by 5 percent below the baseline the number of admissions for immunization-preventable pneumonia for persons aged 65 or older					
	Performance Target:	5 percent below baseline annually.				
	Actual Performance:	743,487 in 2000; 792,264 in 1999.				
	Key Goal III: Reduce by 5 percent below the baseline the number of admissions for immunization-preventable pneumonia for persons aged 65 or older					
	Performance Target:	5 percent below baseline annually.				
	Actual Performance:	16,529 in 000; 17,508 in 1999.				
	Key Goal IV: Reduce by 5 percent below the baseline the number of premature babies who develop RDS.					
	Performance Target:	5 percent below baseline annually.				
	Actual Performance:	Baseline to be determined.				

	Questions	Ans.	Explanation	Evidence/Data	Weighting	Weighted Score
3	*Does the program demonstrate improved efficiencies and cost effectiveness in achieving program goals each year?*	Small Extent	AHRQ's TRIP grants are relatively new, yet goals are being met and TRIP resources are contributing to cost efficiencies in health care settings.		25%	0.1
4	*Does the performance of this program compare favorably to other programs with similar purpose and goals?*	NA			0%	
5	*Do independent and quality evaluations of this program indicate that the program is effective and achieving results?*	Small Extent	The Research Triangle Institute has conducted a formative evaluation of TRIP grants that focused on the efficacy of the program. The evaluation determined that measuring the translation of research into practice is difficult, yet a few illustrative examples of grantee's efforts show progress. The evaluation also suggested that AHRQ could ask a different series of questions to determine the effectiveness of TRIP. As a result, the study also formed the evaluation questions for a comprehensive program evaluation to be conducted in FY 2005.	RTI - Project No 06703-007.	25%	0.1
6 (RD 1)	*If the program includes construction of a facility, were program goals achieved within budgeted costs and established schedules?*	NA			0%	
Total Section Score					**100%**	**33%**

Program Assessment Rating Tool (PART)

Program: Urban Indian Health Program
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	100%	67%	

1.1 Is the program purpose clear? Answer: NO Question Weight: 20%

Explanation: The program purpose is to ensure a comprehensive program of services, or access to services, is developed for each urban Indian community. This purpose is also consistent with the program policy as stated in the Indian Health Manual and with the IHS mission and goal overall. IHS contracts with a range of providers which provide comprehensive and limited primary health care services and/or outreach and referral services. There are significant differences between ensuring comprehensive health care services and access to services. Thus, the mission of the program is not clear. IHS has clarified that the program's purpose is to increase access to critical health care services, with emphasis on primary care by providing them directly or securing them through outreach and referral efforts in an urban setting where over half of the population now live. While this purpose is more focused, it is not reflected in program documentation.

Evidence: Indian Health Manual, Chapter 19, Section 3-19.1C. Section 501 in Title V of the Indian Health Care Improvement Act: "...establish programs in urban centers to make health services more accessible to urban Indians." See also FY 2004 Congressional Justification for IHS mission and goal statements.

1.2 Does the program address a specific and existing problem, interest or need? Answer: YES Question Weight: 20%

Explanation: The problem and need began with the emergence of urban Indian populations after WWII and the BIA relocation program in the 1950's. The 2000 Census indicates that 56 percent of American Indian/Alaska Natives (AI/AN) live in urban areas.

Evidence: There have been local studies that have documented that urban Indians experience excessive health problems compared to all races statistics. In a 1994 Journal of the American Medical Association article, "urban AI/AN [in Seattle] had a much higher rate of low birth weight compared with urban whites and rural AI/ANs [in seven rural counties with reservation land in Washington state] and had a higher rate of infant mortality than urban whites." There is little health status information for urban Indians on a national basis.

1.3 Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort? Answer: NO Question Weight: 20%

Explanation: The services provided by contractors in the UIHP range from outreach and referral to the provision of health care services. While no other public or private organizations target the urban Indian population for the aforementioned range of services, the Consolidated Health Center (CHC) program is a federal grant program funded under Section 330 of the Public Health Service Act to provide for primary and preventive health care services in medically-underserved areas throughout the U.S. and its territories. IHS acknowledges that its program is "conceptually redundant" with the CHC program, but states that its unique approach is "reducing real cultural barriers to health care" for AI/AN in urban areas.

Evidence: In 2001, 49 percent of UIHP's resources came from IHS. The remaining 51 percent came from other sources: Medicaid, Medicare, SCHIP, Ryan White Title III, state, county , city and private sources. The health status of urban AI/ANs is evidence of gaps in access to heath care services. However, the varied and broad range of services resulting from the program purpose in different markets are, in instances, duplicative of other Federal and non-Federal efforts. A July 1988 report issued by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) noted that urban Indians who lack health insurance face barriers to care and recommended a detailed analysis of the barriers to mainstream health care and an action plan to overcome them. The report also recommended that the UIHP be integrated with the CHC program or develop explicit linkages locally between the clinics in the respective programs and nationally between IHS and the Health Resources and Services Administration's Bureau of Primary Health Care.

Program ID: 10001067

Program Assessment Rating Tool (PART)

Program: Urban Indian Health Program
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	100%	67%	

1.4 Is the program design free of major flaws that would limit the program's effectiveness or efficiency? Answer: YES Question Weight: 20%

Explanation: The program design is free of major flaws that would limit the program's effectiveness or efficiency. The UIHP contractors/grantees have been effective in leveraging IHS grant and contract funds with funds from public and private sources in various markets. In addition, UIHP contractor/grantees have expanded total patient visits annually and made measurable progress in its performance measures.

Evidence: In 2001, UIHPs received $38,487,297 from other sources: $17,449,220 federal; $12,100,052 state; $5,155,922 (other); 2,592,314 county; and $1,189,789 city. Direct federal provision of health care services to the urban Indian populations would be significantly more than the $32 million currently appropriated for the contracts and grants in the urban Indian health program. There are no IHS facilties in major urban areas so the infrastructure would have to be developed to carry out the program purpose.

1.5 Is the program effectively targeted, so that resources will reach intended beneficiaries and/or otherwise address the program's purpose directly? Answer: NO Question Weight: 20%

Explanation: The UIHP contract and grant funds are distributed based on historical base funding for existing programs. A small portion of the contract funds are allocated on the basis of Indian Users per program as an incentive to get UIHPs to input data into the UIHP Common Reporting Requirements (UCRR) system .

Evidence: As an incentive to increase the UIHPs input of data into the UCRR, IHS distributed $937,000 of the $20,843,979 in contract funds on the basis of AI/AN users per program. This incentive resulted in an increase in system usage from 70 percent to 100 percent. To ensure that resources reach the intended beneficiaries, however, it would seem that it would be appropriate to distribute more than four percent of these funds based upon AI/AN users per program.

2.1 Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program? Answer: YES Question Weight: 12%

Explanation: The UIHP has adopted specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program.

Evidence: (1) Decrease the Years of Potential Life Lost (YPLL) for the AI/AN urban populations served by the UIHP; (2) Increase "ideal" (based on American Diabetes Association Guidelines) blood sugar control in the AI/AN population diagnosed with diabetes; (3) Decrease obesity rates in AI/AN children (2-5 years) served by the UIHP; and (4) All urban programs will have an automated patient record system and data warehouse that is fully compatible with the IHS automated patient records system.

Program ID: 10001067

Program Assessment Rating Tool (PART)

Program: Urban Indian Health Program
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	100%	67%	

2.2 Does the program have ambitious targets and timeframes for its long-term measures? Answer: YES Question Weight: 12%

Explanation: The UIHP has ambitious targets for its four long-term measures.

Evidence: By 2010: (1) Decrease the YPLL by 10%; (2) Increase "ideal" blood sugar control by 40%; (3) Decrease obesity rates in AI/AN children (2-5 years) by 4%; and (4) All urban programs will have an automated patient record system and data warehouse that is fully compatible with the IHS automated patient records system. The "ideal" blood sugar control long-term performance goal target is equal to the goal for the IHS federally-administered program. The long-term performance goal target for YPLL is half of the goal for the IHS federally-administered program. The long-term performance goal target for obesity rates in children is consistent with the Healthy People 2010 goal for obesity rates for children. It is necessary to note, that the Healthy People 2010 5 percent reduction goal is for children 6-19 years. Healthy People 2010 does not have a goal for children 2-5 years. Differing outcome targets are appropriate given the differences in the administration of the programs: federal control versus contractors/grantees.

2.3 Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals? Answer: YES Question Weight: 12%

Explanation: The UIHP has a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals.

Evidence: (1) Decrease the Years of Potential Life Lost (YPLL) for the AI/AN urban populations served by the UIHP; (2) Maintain the level of glycemic control in the proportion of the urban AI/AN population with diagnosed diabetes; (3) Decrease obesity rates in AI/AN children (2-5 years) served by the urban Indian health program; and (4) Increase the number of urban programs that implemented mutually compatible automated information systems which capture health status and patient care data.

2.4 Does the program have baselines and ambitious targets for its annual measures? Answer: YES Question Weight: 12%

Explanation: The UIHP has baselines and targets for most of its annual measures. Specifically, the UIHP has baselines and targets for three of the four annual measures mentioned above: YPLL, glycemic control and information systems. The baseline and target for obesity rates for AI/AN children is under development.

Evidence: During 2003: (1) Efficiency measures of cost per encounter and cost per service user will be utilized to track the annual performance of YPLL for the AI/AN urban populations served by the UIHP; (2) Maintain the level of glycemic control in the proportion of the AI/AN population served by the urban Indian health program; (3) Decrease obesity rates in AI/AN children (2-5 years) served by the urban Indian health program; and (4) Increase by two sites the number of of urban programs that have implemented mutally compatible automated information systems which capture health status and patient care data. During 2003, the UIHP is establishing baseline rates for obesity rates in children. A target for this annual measures will be established in 2004.

Program ID: 10001067

Program: Urban Indian Health Program
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	100%	67%	

2.5 **Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?** Answer: YES Question Weight: 12%

Explanation: The UIHP contractors and grantees commit to and work toward the annual and/or long-term goals of the program.

Evidence: The UIHP contractors/grantees participation in the I/T/U (IHS/Tribal/Urban) consultation process not only affords UIHPs the opportunity to show commitment to the annual and long-term goals, but allows their input in the development of the goals. Also, the scope of work and contract language between IHS and the contractors/grantees particpating in the UIHP include commitment to the IHS mission, annual and long-term performance goals, treatment priorities and data submission requirements.

2.6 **Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?** Answer: NO Question Weight: 12%

Explanation: Independent evaluations of sufficient scope and quality are not conducted on a regular basis. As mentioned above, the last independent evaluation of sufficient scope for the UIHP was conduted in July 1988. The IHS Area UIHP coordinators conduct annual reviews of urban programs. In addition, all urban programs submit an annual program profile addressing staffing patterns, services provided, target population and accreditation to the IHS UIHP. However, independent evaluations only potentially impact 22 of the 34 contractor/grantees in the program as Federally Qualified Health Centers (FQHC) and as participants in state Medicaid programs. There is not adequate evidence to show that the FQHC and state licensing recertification process is of sufficient scope and quality to evaluate program effectiveness so that IHS can use the information to improve the program.

Evidence: Of the 21 "comprehensive" programs, 19 are FQHC. One of the six "limited "programs are FQHC; two other programs in this category are undergoing the process for acquiring FQHC status. Four of the "comprehensive" programs are accredited by JCAHO (two) and AAAHC (two).

2.7 **Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** Answer: NO Question Weight: 12%

Explanation: The UIHP is not able to provide a valid cost accounting link to health outcomes by specific activity and respective funding sources.

Evidence:

2.8 **Has the program taken meaningful steps to correct its strategic planning deficiencies?** Answer: YES Question Weight: 12%

Explanation: The IHS Director has established a workgroup of UIHP stakeholders to work with the UIHP Director to develop a corrective action plan for addressing all deficiencies identifed by the PART assessment process in addition to making recommendations for the restructuring of the UIHP to assure consistency and support in policy implementation, dissemination of innovations and best practices across urban programs, expanded partnerships and collaborations and improved data systems. The UIHP is able to determine the average cost of encounter and service, but is not able to provide a valid cost accounting link to health outcomes by specific activity. The UIHP is working to complete the baselines for its annual goals in 2003 and will set targets in 2004. HHS OIG will incorporate a UIHP follow-up study in its next work plan.

Evidence:

Program ID: 10001067

Program Assessment Rating Tool (PART)

Program: Urban Indian Health Program
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	100%	67%	

3.1 **Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** Answer: YES Question Weight: 12%

Explanation: The UIHP collects timely and credible performance information from key program partners and uses it to manage the program and improve performance.

Evidence: Non-compliant programs are issued a timely corrective action plan. The programs submit quarterly progress reports to the Urban Area Coordinators who audit and track the reports to assure that the programs are complying with the corrective action plan.

3.2 **Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** Answer: YES Question Weight: 12%

Explanation: The UIHP Director and the Area Directors have elements in their performance plan to achieve performance measures. The program partners are held accountable through the reporting requirements of their contracts and grants and the findings of their annual IHS Area reviews.

Evidence: In addition to performance goals, the Area Directors also have a financial element in their peformance plan to assess their management of agency resources. The program partners are held accountable for their IHS resources under contracts and grants through their program reports, audits, annual reviews and the elements of the Area Direcors and UIHP Directors performance appraisal system.

3.3 **Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** Answer: YES Question Weight: 12%

Explanation: The UIHP and its partners obligate funds in a timely manner and spend the funds for the intended purpose.

Evidence: Contract funds for the UIHP are distributed to the Area Offices shortly after apportionment. The Area Offices distribute the funds to the program partners based on the contract, usually on a calendar year basis. Grant funds for the UIHP are awarded at four different times throughout the year: January; October; April; and June.. The UIHP Director and staff track obligations and conduct monthly conference calls with Area UIHP coordinators to discuss obligations and cash flow.

3.4 **Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?** Answer: YES Question Weight: 12%

Explanation: The UIHP has utilized incentives and procedures such as competitive sourcing and IT improvements to measure and achieve efficiencies and cost effectiveness in program execution.

Evidence: The UIHP provided a funding incentive to increase contractors and grantees use of the UIHP UCRR system from 70 percent to 100 percent. The UCRR data collection is competitively sourced to a private vendor and contract and grant payments are administered by the Program Support Center in HHS. The IHS Information Technology Service Center is being utilized for the UIHP's Data Mart pilot project to develop an automated patient record system and data warehouse for the contractors and grantees. The $50 million increase in mandatory diabetes funds will be distributed by IHS through a competitive grants process for all participants, including grantees in the UIHP.

Program ID: 10001067

Program Assessment Rating Tool (PART)

Program: Urban Indian Health Program
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	100%	67%	

3.5 **Does the program collaborate and coordinate effectively with related programs?** Answer: YES Question Weight: 12%

Explanation: The UIHP collaborates and coordinates effectively with related programs as many of the contractors and grantees receive resources from various public and private sources. In addition, the intended beneficiaries, the urban Indian population, often receive services from multiple sources.

Evidence: The UIHP and its contractors and grantees work with related programs such as the Office of Minority Health in HHS, Department of Veterans Affairs, Health Resources and Services Administration's 330 Consolidated Health Center program, and state, county and local government programs.

3.6 **Does the program use strong financial management practices?** Answer: YES Question Weight: 12%

Explanation: The UIHP Director works with the Head Contracting Official for Acquisitions, Grants Mangement Officer, and Area Directors to oversee the financial management practices of the contractors/granteees.

Evidence: There are no material weaknesses in the audited financial statements related to the UIHP.

3.7 **Has the program taken meaningful steps to address its management deficiencies?** Answer: NA Question Weight: 0%

Explanation: No management deficiencies were identified in this analysis.

Evidence:

3.BF1 **Does the program have oversight practices that provide sufficient knowledge of grantee activities?** Answer: YES Question Weight: 12%

Explanation: The UIHP has oversight practices that provide sufficient knowledge of grantee activities.

Evidence: Contractors and grantees submit monthly/quarterly financial reports to Area Offices. Area Offices also conduct an annual review of the grantee continuation applications. Area Office project officers conduct annual site visits of grantees.

3.BF2 **Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?** Answer: YES Question Weight: 12%

Explanation: The UIHP collects grantee performance data on an annual basis and makes it available to the public in a transparent and meaningful manner.

Evidence: Data is gathered annually from the grantees in the UCRR and displayed on the IHS website (www.ihs.gov). The data is arrayed in aggregate and by program for each of the categories. In addition, grantee performance information is collected by IHS for aggregate reporting of GPRA measures in the Congressional Justification. New long-term and annual performance measures adopted by IHS will report specifically on UIHP performance.

Program ID: 10001067

Program Assessment Rating Tool (PART)

Program: Urban Indian Health Program
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	100%	67%	

4.1 Has the program demonstrated adequate progress in achieving its long-term performance goals? Answer: LARGE EXTENT Question Weight: 25%

Explanation: The program has demonstrated adequate progress on three of its four long-term performance goals: YPLL; achievement of "ideal" blood sugar control; and establishing an automated patient record system and data warehouse in all urban programs. IHS is developing a baseline and targets for the obesity long-term and annual measures.

Evidence: The UIHP is able to demonstrate a 12.4 percent reduction in the YPLL rate from 58.6/1000 in 1994-96 to 51.3/1000 in 1997-99. IHS is also able to demonstrate progress for the UIHP with respect to the "ideal" blood sugar control measure. From 2000 through 2002, the percentage of urban AI/AN diabetics meeting the "ideal" standard are 30 percent, 31 percent and 34 percent, respectively. In FY 2002, IHS increased the number of programs using an automated patient record system and data warehouse to 13 from a baseline of 11 in FY 2001.

4.2 Does the program (including program partners) achieve its annual performance goals? Answer: LARGE EXTENT Question Weight: 25%

Explanation: The UIHP has baselines and targets for three of its four annual measures: YPLL (cost per service user and cost per encounter are two efficiency measures used to track performance of YPLL); "ideal" blood sugar control; and establishing an automated patient record system and data warehouse in all urban programs.

Evidence: The UIHP increased patient visits from 423,049 in 1999 to 586,390 in 2002. Expanding patient visits is one of the 15 annual GPRA measures used to track performace of YPLL. An efficiency measure of patient visits per dollar will be used to track annual performance of YPLL. From 2000 through 2002, the percentage of urban AI/AN diabetics meeting the "ideal" standard are 30 percent, 31 percent and 24 percent, respectively. Also, in FY 2002, IHS increased the number of programs using an automated patient record system and data warehouse to 13 from a baseline of 11 in FY 2001.

4.3 Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year? Answer: YES Question Weight: 25%

Explanation: The UIHP is able to demonstrated improved efficiencies and cost effectivenss in achieving program goals each year evinced by increases in leveraged funding and a relatively modest appropriation increases.

Evidence: As mentioned above, leveraged funding accounts for 51 percent of UIHPs annual funding. Federal appropriations for the UIHP increased from $28 million in 2000 to $31 million, 11 percent. UIHP funding relative to the total IHS budget has remained constant over the same time period from 1.16 percent in 2000 to 1.12 percent in 2002. UCRR data from 2000 through 2002, shows that total service encounters in the UIHP have increased from 483,441 to 586,390, 21 percent.

4.4 Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals? Answer: NA Question Weight: 0%

Explanation: There are no comparisons of urban health care programs that provide funds that target a specific ethnic population with the variance in program participant's size and services as managed by the urban Indian health program.

Evidence:

Program ID: 10001067

Program Assessment Rating Tool (PART)

Program: Urban Indian Health Program
Agency: Department of Health and Human Services
Bureau: Indian Health Service
Type(s): Block/Formula Grant

Section Scores				Overall Rating
1	2	3	4	Adequate
40%	75%	100%	67%	

4.5 Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?

Answer: SMALL EXTENT

Question Weight: 25%

Explanation: As mentioned above, no independent evaluations of sufficient scope and quality have been conducted to show that the program is effective and achieving results. In addition, baselines and targets are under development for two of the four annual measures.

Evidence: Independent evaluations potentially impact 22 of the 34 contractor/grantees (65 percent) in the program as Federally Qualified Health Centers (FQHC) and as participants in state Medicaid programs. There is not adequate evidence to show that the FQHC and state licensing recertification process is of sufficient scope and quality to evaluate program effectiveness so that IHS can use the information to improve the program. IHS UIHP Area staff do conduct annual reviews of the program. Partial credit is given here for demonstrated progress by the UIHP on achieving results with respect to "ideal" blood sugar control and establishing an automated patient record system and data warehouse in all urban programs.

Program ID: 10001067

PART Performance Measurements

Program: Urban Indian Health Program

Agency: Department of Health and Human Services

Bureau: Indian Health Service

Measure: Percent decrease in years of potential life lost

Additional Information: This measure is an estimate of premature mortality defined as the number of years of life lost among persons before the age of 65.

Year	Target	Actual	**Measure Term:**	Long-term
2010	10%			

Measure: Increase percent of diabetics with "ideal" blood sugar control

Additional Information: This measure is directed at reducing complications of diabetes. The "ideal" control standard is defined as 130/80.

Year	Target	Actual	**Measure Term:**	Long-term
2010	40%			

Measure: Percent decrease in obesity rates in children (2-5 years)

Additional Information: This measure is directed at reducing obesity through breastfeeding counseling and school and community-based interventions.

Year	Target	Actual	**Measure Term:**	Long-term
2010	4%			

Measure: Cost per service user in dollars per year

Additional Information: This measure is one of two efficiency measures that most impact the years of potential life lost measure.

Year	Target	Actual	**Measure Term:**	Annual	(Efficiency Measure)
2003	$483				
2002		$483			
2001		$359			
2000		$385			
1999		$265			

PART Performance Measurements

Program: Urban Indian Health Program

Agency: Department of Health and Human Services

Bureau: Indian Health Service

Measure: Percent of diabetics with "ideal" blood sugar control

Additional Information: This measure is directed at reducing complications of diabetes. The "ideal" blood sugar control standard is defined as 130/80. The goal is to increase the number of diabetics that maintain this control standard.

Year	Target	Actual	**Measure Term:** Annual
2003	34%		
2002		34%	
2001		31%	
2000		30%	

Measure: Percent decrease in obesity rates in children (2-5 years)

Additional Information: This measure is directed at reducing obesity through breastfeeding counseling and school and community-based interventions.

Year	Target	Actual	**Measure Term:** Annual
2003	Baseline		

Measure: Number of urban programs using automated patient record system and data warehouse

Additional Information: This meausre is directed at ensuring that all urban programs have in place an automated patient record system and data warehouse that is fully compatible with the IHS automated patient records system.

Year	Target	Actual	**Measure Term:** Long-term
2010	34		

Measure: Number of urban programs using automated patient record system and data warehouse

Additional Information: This measure is directed at ensuring that all urban programs have in place an automated patient record system and data warehouse that is fully compatible with the IHS automated patient records system.

Year	Target	Actual	**Measure Term:** Annual
2003	15		
2002	13	13	
2001		11	

PART Performance Measurements

Program: Urban Indian Health Program

Agency: Department of Health and Human Services

Bureau: Indian Health Service

Measure: Cost per encounter

Additional Information: This measure is one of two efficiency measures that most impact the years of potential life lost measure.

Year	Target	Actual
2003	$113	
2002		$113
2001		$74
2000		$79
1999		$111

Measure Term: Annual