United States Department of
Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Chief Financial Officer's Financial Management Status Report and Five-year Plan

2000

Fiscal Year

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Administration on Aging (AoA)	**www.aoa.dhhs.gov**
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Indian Health Service (IHS)	**www.ihs.gov**
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Program Support Center (PSC)	**www.psc.gov**
Substance Abuse and Mental Health Services Administration (SAMHSA)	**www.samhsa.gov**

Message From the Chief Financial Officer and Deputy Chief Financial Officer

We are pleased to present the FY 2000 HHS Financial Management Status Report and Five-Year Plan. This plan provides details on our strategies for achieving our two broad-based financial management goals:

- Decision Makers Have Timely, Accurate, and Useful Program and Financial Information, and
- All Resources are Used Appropriately, Efficiently, and Effectively.

As we have done in past Five-Year plans, we have quantified performance targets for the next five years for each of our performance measures. We have also improved the quality of our measures this year, adding some new measures and deleting some others that were less informative than we would like. Actual results achieved will be published in our annual Accountability Report.

As we look forward five years and chart the course for HHS financial management activities, we can also look back at the last five years of significant accomplishments, including:

- Ensuring that our information technology operated successfully in the Year 2000,
- Obtaining our first clean and timely financial statement audit opinion for FY 1999;
- Implementing the Prompt Payment Act and the Travel and Transportation Reform Act;
- Achieving annual increases in the collection of debt owed to HHS; and
- Awarding and administering over fifty percent of all Federal grants.

The years ahead present numerous challenges as we deal with issues related to maintaining a skilled Federal workforce, upgrading complex financial information systems, resolving internal control weaknesses, and partnering with our senior managers on Departmental strategies. The financial managers at HHS will greet these challenges with enthusiasm and dedication. We trust that readers of this plan will find it useful and informative.

Sincerely,

John J. Callahan George Strader

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INTRODUCTION

INTRODUCTION

WHO WE ARE AND WHAT WE DO

The Department of Health and Human Services is the federal government's principal agency whose mission is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services.

HHS accomplishes its mission by providing leadership in the administration of programs to improve the health and well being of Americans and to maintain the United States as a world leader in biomedical and public health sciences.

The Department manages more than 300 programs, covering a wide spectrum of activities that impact all Americans, whether through direct services, benefits of advances in science, or information that helps them to live better and make healthy choices. These programs include:

- Conducting and sponsoring medical and social science research
- Preventing outbreak of infectious disease, including immunization services and eliminating environmental health hazards
- Assuring food and drug safety
- Providing health insurance for elderly and disabled Americans (Medicare) and health insurance for low-income people (Medicaid)
- Providing financial assistance and employment support/services for low-income families
- Providing access to primary health care services for the underserved and unserved
- Supporting of persons with HIV/AIDS
- Facilitating child support enforcement
- Improving maternal and infant health
- Ensuring pre-school education and services (Head Start)
- Preventing child abuse and domestic violence
- Improving the quality and availability of substance abuse prevention and treatment, and mental health services
- Providing critical services for older Americans, including home-delivered meals.

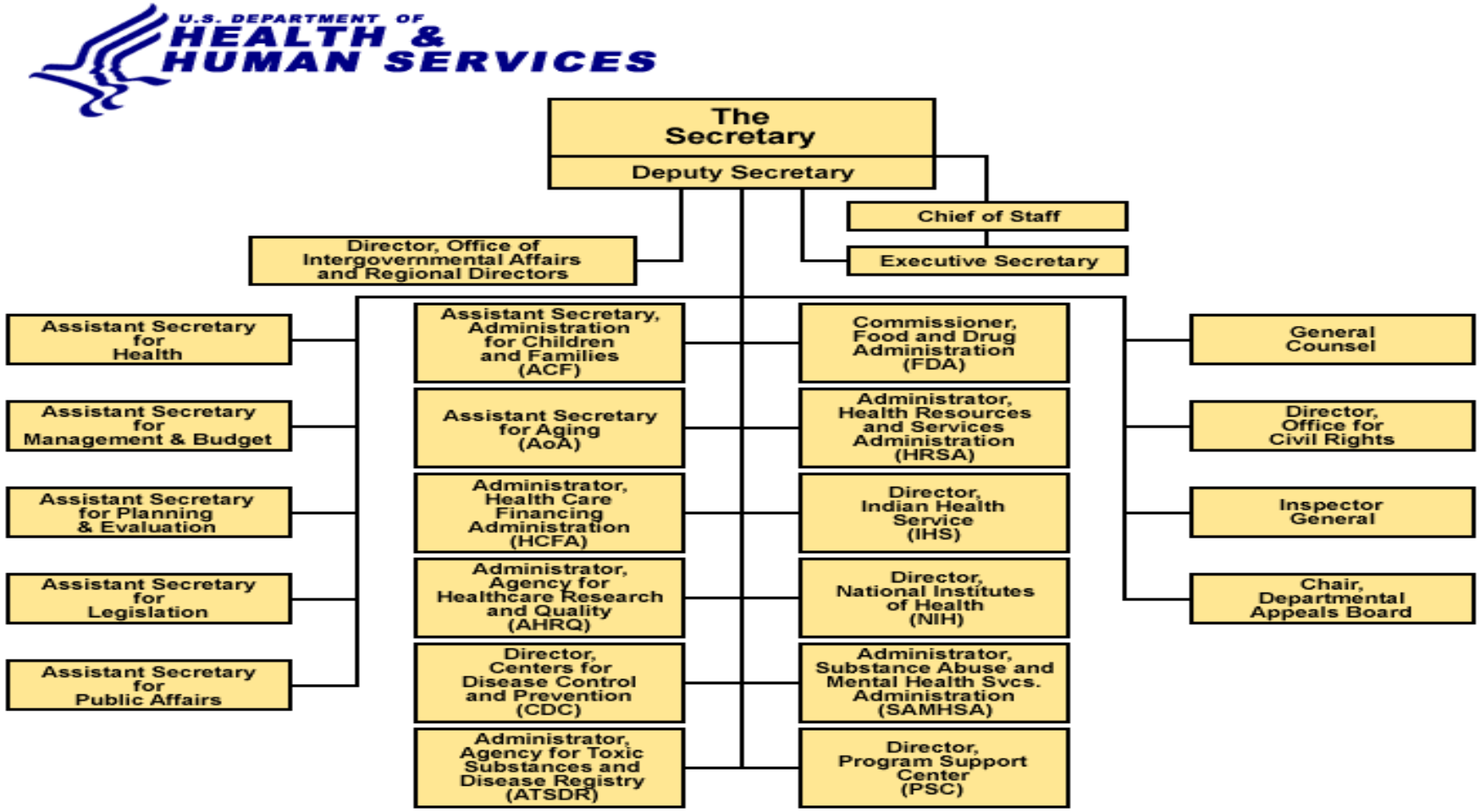
In addition to the services they deliver, the HHS programs provide for equitable treatment of beneficiaries nationwide, and they facilitate the collection of national health and other data for research and publication. HHS works closely with state and local governments, private sector grantees and other partners to accomplish its programs.

The total net cost (costs incurred) of HHS operations for FY 1999 was $358.4 billion.
The FY 1999 net budget outlay (disbursements) for the HHS programs was $359.7 billion.

HOW WE ARE STRUCTURED TO ACCOMPLISH OUR MISSION

Because of the complexity and importance of the many issues involved in its mission, and consistent with the intention of congressional legislation, 13 HHS operating divisions (OPDIVs) administer the Department's programs. A chart of the current organizational structure of HHS follows. Leadership is provided by the Office of the Secretary (OS), which is also considered one of the 13 OPDIVs. HHS is also active in ten regions throughout the United States to coordinate the crosscutting and complementary efforts that are needed to accomplish our mission. Offices of the General Counsel, Civil Rights, Inspector General, Departmental Appeals Board, and Intergovernmental Affairs also support this mission across the Department. HHS Headquarters is located at 200 Independence Avenue SW, Washington, D.C., 20201.

The current HHS organizational chart follows on the next page:


U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
The Secretary
Deputy Secretary
Chief of Staff
Executive Secretary
Director, Office of Intergovernmental Affairs and Regional Directors
Assistant Secretary for Health
Assistant Secretary for Management & Budget
Assistant Secretary for Planning & Evaluation
Assistant Secretary for Legislation
Assistant Secretary for Public Affairs
Assistant Secretary, Administration for Children and Families (ACF)
Assistant Secretary for Aging (AoA)
Administrator, Health Care Financing Administration (HCFA)
Administrator, Agency for Healthcare Research and Quality (AHRQ)
Director, Centers for Disease Control and Prevention (CDC)
Administrator, Agency for Toxic Substances and Disease Registry (ATSDR)
Commissioner, Food and Drug Administration (FDA)
Administrator, Health Resources and Services Administration (HRSA)
Director, Indian Health Service (IHS)
Director, National Institutes of Health (NIH)
Administrator, Substance Abuse and Mental Health Svcs. Administration (SAMHSA)
Director, Program Support Center (PSC)
General Counsel
Director, Office for Civil Rights
Inspector General
Chair, Departmental Appeals Board

THE PURPOSE OF THIS PLAN AND STATUS REPORT

This new century calls for a basic reassessment of the responsibilities of the Chief Financial Officer (CFO). Fast paced developments in communications and commerce and heightened expectations by our citizens and taxpayers require that the CFO play an increasingly significant part in the financial management and strategic direction of agency operations. In short, the CFO must be a senior partner in Federal agency management, insuring that the programs of a department are carried out in an efficient and cost-effective manner and in a way that takes full advantage of breaking technological developments and achieves the highest standard of program integrity.

Our FY 2000 CFO Financial Management Status and Five-Year Plan demonstrates the commitment and contributions of the HHS CFO and OPDIV CFOs to efficient and cost effective programs.

Strategic Benefit for the American People

We are committed to achieving improvement in the health and well being of the American people. Through our financial management support of the delivery of HHS programs, we are confident that we will contribute to a successful outcome.

States, local governments, and community networks, for instance, rely on HHS to enable them to provide needed services to improve health by making timely and accurate grant payments.

Our Vision

Managers at all levels work with our program partners to provide services to the American People and to solve problems seamlessly across traditional fiscal and program boundaries, in order to achieve better program results.

Our CFO Strategic Goals

To achieve our vision and the benefits for the American people, we have specifically committed to these two CFO strategic goals:

1. *Decision-makers have timely, accurate, and useful program and financial information, and*
2. *All resources are used appropriately, efficiently, and effectively.*

These goals support all of the six HHS Government Performance and Results Act (GPRA) strategic plan goals for our programs. They

also support the six management priorities of the Office of Management and Budget (OMB) and the CFO Council for implementing government-wide improvements in financial management. These are listed in Appendix E.

Our Challenges

Our key financial management challenges in the next five years are generally the same management challenges that were identified in our HHS GPRA strategic plan. They include: continue to move toward results-oriented management; increase cooperation and integration of efforts across organizational and functional lines; increase use of partnerships to accomplish results; and develop and support a committed, skilled, and diverse work force. Appendices A through D explain how we are addressing the challenge of maintaining a clean audit opinion.

Our Strategies for Getting There

These challenges will be overcome and our vision will be achieved only through planning and accountability for results. In particular, financial and program managers should be jointly accountable for program results. To accomplish these results, a CFO needs to align the many financial management functions that impact programs, so they work together through providing good, responsive service, plus timely and accurate information on financial matters that helps program managers to achieve successful program results.

We are also working with the HHS Inspector General's staff and commercial auditors to resolve financial management problems identified in annual audits.

Therefore, the complementary CFO Five-Year Plan and the GPRA Annual Performance Plan that are both submitted with the budget justification, identify financial and program commitments, respectively. Key financial and program results are then linked in the HHS Accountability Report to show the program performance results for the funds invested in them. Several financial management goals such as the achievement of the clean audit opinion, reducing the Medicare Fee-for-Service error rate, and improving electronic data processing controls, are integral to a program's integrity and success so they are also included in OPDIV GPRA annual performance plans.

Our success should be measured in steady improvements.

Financial management as described in this plan, consists of those functions that affect or contribute to the financial condition and resources of HHS programs. They include, for example: budget, information management, acquisition, grants, logistics, real property management, and human resources functions, as well as the traditional finance functions.

We also have the specific challenges of complying with evolving financial standards and management initiatives, while finding new and better ways to integrate finance, budget, and performance information. We have addressed these challenges in the performance goals and measures.

Approach to the FY 2000 Five-Year Plan

In the FY 2000 Five-Year Plan, HHS has continued to improve the presentation in order to show a more performance-oriented plan that reflects accountability for results. The plan presents quantitative goals and measures with more baselines and targets; puts context into the plan by briefly describing HHS and its programs; reconciles audit findings with planned activities; and displays more data sources in support of the quantitative commitments. The new approach was developed in FY 1998 in strategic planning sessions with our components and reflects their subsequent comments and individual commitments, which are critical to the credibility and the long-term effectiveness of the plan.

This year we continued to streamline the development of this report through an electronic application that allows for easier submission and tracking of performance by the OPDIVs and HHS. This database also contains the explanation of the measures, the source of the data, and actual results. We will continue to improve our verification and validation of all of these measures. Also, we clarified targets by showing simple fiscal year targets, rather than showing a target in FY 2000 for an audit opinion on financial statements of the prior year, FY 1999, for example. The FY 2000 audit opinion targets now show up in FY 2000 since the financial statements are for the period of FY 2000, rather than for FY 2001 when the opinion is issued.

Compared to the FY 1999 Plan, this plan reflects further refinements in the presentation of goals and measures; some have been merged, deleted or added to reflect accomplishment of goals, elimination of duplication, and new initiatives.

This approach also reflects a natural progression from a focus on GPRA compliance to achieve the integration of performance results into our day-to-day activities. For this reason, there is no separate GPRA implementation section in the plan this year; instead there are specific measures for program performance information.

We have addressed the challenges that we face with appropriate performance goals, measures, and targets. Our commitment to our customers is apparent in the strategy discussions and in the specific goals, measures, and targets that address their particular concerns.

Resources Required to Accomplish this Plan

Resources needed to accomplish this plan are identified as required in Sections 52 and 53 of the FY 2002 Budget Justification and in the corrective action plans presented in appendices to this Five-Year Plan.

Fiscal Year 1995-1999 Accomplishments

In preparing this FY 2000 plan, we also considered what we have accomplished with our resources over the past five fiscal years. Annual financial management performance is included in the HHS Accountability Report. The organizational, systems, and financial accountability improvements in FY 1999 show a steady progress toward our strategic goals and vision. For example, we improved our Department-wide financial statement audit opinion, improved our grant processes, collected more debt owed to the Federal Government, and strengthened our internal controls, to name just a few items. Our FY 2000 accomplishments will be detailed in our FY 2000 Accountability Report, which will be available in March 2001. We will continue to build on our past successes in FY 2000 and beyond.

Following are highlights of what was accomplished from FY 1995 -1999, plus our progress to date in several key areas.

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HHS Major Financial Management Accomplishments of the Past Five Years

Strategic Goal I: Decision-Makers Have Timely, Accurate and Useful Program and Financial Information

Financial Statement Audits

- Achieved a "clean and timely" opinion on the HHS and HCFA FY 1999 financial statements, accounting for over $358 billion and $294 billion in net costs, respectively. Achieved annual improvements since the FY 1996 audit, which received a disclaimer of opinion from the auditors.
- Achieved "clean" opinions on 7 other OPDIVs for FY 1999, 5 for the first time. Five years earlier, none of those OPDIVs had been audited.
- Developed and tracked OPDIV and HHS-level Corrective Action Plans to resolve financial statement audit findings.
- Initiated and conducted annual training sessions for parties involved in the HHS financial statements preparation and audit process since 1996, providing continuing professional education credits to attendees.
- Developed the Financial Information Reporting System (FIRS). The system is instrumental in helping the Department comply with budget caps under the Budget Enforcement Act.

Budget Process

- Achieved continuous improvements in the budget formulation process over the past five years. Innovations include: an open and fully transparent decision-making model; thematic presentation of the budget to OMB; outstanding support for Secretarial Appeals; improved flow of information to OPDIVs; on-time delivery of Congressional Justifications and other materials to the Hill; and, adoption of a governmentwide requirement for administrative cost estimates for implementing mandatory legislation.
- Prepared and distributed A Guide to Budget Scorekeeping, an overview of the history, laws and principles that form the process of scoring legislation and enforcing budgetary rules.
- Played a critical leadership role in the enactment of the Secretary's one-percent transfer authority enacted in 1996. This authority has been exercised each year since enactment, most prominently to provide critical resources to HCFA for Y2K remediation and for OEP's Metropolitan Medical Response System.

Implementation of Major Laws

- Led a comprehensive HHS Annual Government Performance and Results Act (GPRA) program and incorporated a HHS Annual Performance Summary into the budget process.
- Implemented the Travel and Transportation Reform Act of 1998, coordinating with management and union representatives to ensure mandatory travel card usage.
- Succeeded in implementing the Prompt Pay Act of 1982 by surpassing the target rate of vendor prompt payments and achieving a 96.4% rate in FY 1999.

Strategic Goal II: All Resources are Used Appropriately, Efficiently, and Effectively

Organizational Structure

- Improved administrative efficiencies by closing the Department's regional finance offices and transferring the functions to the Program Support Center.
- Established the Office of Public Health and Science.

Payments and Collections

- Continued our concerted efforts to ensure Medicare payments are paid correctly. Maintained the reduction in the Medicare fee-for-service program error rate at 7.97% in FY 1999, from a high of 14% in FY 1996.
- Supported children through HHS partners under the Child Support Enforcement Program that locates parents, establishes paternity, and enforces child support orders. As of December 30, 1999 child support collections were $15.5 billion (based on information previously published as of 2/11/2000).
- Increased the collections of debt owed to HHS to $14.2 billion in FY 1999, a 7% increase over FY 1998.
- Achieved a 96.4% "on time" rate for payments to vendors in FY 1999, exceeding our target of 95%.

Grants and Acquisitions

- Awarded nearly $158 billion of the total federal grants awarded (estimated to be over $250 billion).
- Negotiated cost allocations that have produced over $2.19 billion in cost reductions and cash refunds of $181million over the past five fiscal years.

- Administered approximately 280 thousand procurement actions (excluding purchase card transactions), worth more than $3.7 billion in FY 1999.
- Submitted the Department's first annual Commercial Activities Inventory under the FAIR Act, and set in place a procedure for responding to challenges and appeals.

Electronic Commerce

- Continued to exceed the Treasury regulation goal of 69% of payments via Electronic Funds Transfer (EFT) by making 100% of grant payments and 99 % of salary payments via EFT.
- Continued to improve our rate of vendor and travel payments made via EFT to 85% and 93%, respectively.
- Used purchase cards to conduct over 500 thousand micro-purchases.
- Managed the Department's transition to the U.S. Bank VISA travel charge card.

Capital Assets – Technology

- Succeeded in preparing information systems, telecommunication systems, and facilities for the Year 2000.
- Established the Information Technology Review Board to establish criteria for Department level approval of new major systems projects.
- Developed capital planning and investment control policy for improved capital planning and acquisitioning.

Capital Assets – Facilities and Property

- Implemented a Department-wide database of real property using the Foundation Information for Real Property Management (FIRM) database.
- Coordinated the evaluation, remediation and reporting process ensuring that major building systems in each of the 4,100 HHS owned, managed and occupied facilities were Y2K compliant.
- Implemented a cost-effective Department-wide energy and water conservation program. Since the program's inception, HHS has saved over $7.8 million and approximately 332,742 million BTUs of energy.

Human Resources

- Developed and launched a pilot program to provide mediation as an alternative to traditional EEO counseling for employees in OS and AoA who file informal EEO complaints.

HOW HHS PLANS AND MEASURES ITS PERFORMANCE

In the following pages are the commitments that HHS and its OPDIVs have made toward accomplishing the two financial management strategic goals. The targets shown are fiscal years from October through September of the following year. The actual performance toward meeting the targets will be reported in the HHS Accountability Report to be issued annually in March. Although the plan is for FY 2001 through FY 2005, FY 2000 targets are included to relate the plan to current year efforts.

To help the reader, the framework of the plan is a cascade of elements in descending order that contribute to successful levels of performance.

Strategic Goal—The department-wide long-term level of performance that the HHS financial management functions are working to achieve. They are the "big picture" results of HHS functions. The Chief Financial Officers Act defines these functions.

Strategy—A general description of the long-term or continuing need and the method, approach, or tools that will be used to achieve the strategic goals.

Performance Area—Strategic goals are inherently general, and broad. Therefore, performance areas are the key areas where we need to focus activities in order to accomplish those goals.

Performance Goal—A tangible, measurable objective against which annual actual achievements can be compared. Performance goals should reflect the annual, incremental progress toward achieving the strategic goals. In the financial management functions, these annual objectives may be improvements in products, services, activities, or tasks that evolve to results over time. For example, an initial performance goal of issuing guidance or improving the recording and accuracy of financial transactions becomes a performance goal of timely and accurate reports, then a performance goal of obtaining a clean audit opinion, then a performance goal of integrating accurate finance, budget, and performance information into a useful format for decision makers, and finally, increased use of that information to improve program performance.

The performance goals in this CFO Five-Year Plan reflect the various stages of becoming more results-oriented.

Performance Measure—How HHS will determine whether it has met or not met annual performance goals. Performance measures are the "rulers" that will be used to do this.

Baseline—The documented, quantifiable data used to compare with actual performance to determine how much performance has improved/not improved. It is the starting point and the basis for determining whether targets were met. For the purpose of the HHS CFO Five Year Plan, many baselines were the actual performance level for FY 1998 or FY 1999.

Target—The specific level of performance that is planned for a particular year. It represents an improvement over the baseline performance. It will be a number or a percentage in most cases; although there are a few cases where activities are identified. When a percentage is used, the basis for the percentage is also identified.

STRATEGIC GOAL 1:

DECISION MAKERS HAVE TIMELY, ACCURATE, AND USEFUL PROGRAM AND FINANCIAL INFORMATION

HHS CFO's Financial Management FY 2000 Five -Year Plan Covering Fiscal Years 2000 - 2005

Strategic Goal 1: Decision-Makers Have Timely, Accurate, and Useful Program and Financial Information.

Federal managers are experiencing growing pressures from their executive leaders, Congress, the public and their customers to achieve more under the programs they manage. To succeed, they need the best financial and performance information about their programs to make informed decisions and to accurately evaluate performance and cost data.

The CFO community has a responsibility to respond to these needs by ensuring that the financial information for programs is accurate and usable and that the financial systems and processes that support them maintain the highest level of integrity. The HHS CFO community is leading an effort to strengthen the ability to provide sound financial information by focusing on the accuracy, accessibility, and usefulness to program managers and other customers.

Strategy 01 A: Maintaining an Unqualified Opinion on Our Financial Statements.

For the coming years, one of our highest priorities is to maintain our focus on earning unqualified or "clean" audit opinions for all of our audited OPDIVs' financial statements (including those who have not yet obtained it), and for our departmental financial statements. This means that we will fairly present and report on our financial condition in accordance with generally accepted accounting principles.

The HHS CFO is committed to continuing to earn a "clean" opinion on the departmental financial statements for FY 2000 and beyond. The HHS CFO community will continue to improve the quality, timeliness, and most importantly, the usefulness of the financial information presented in our statements.

The departmental statements and OPDIV level statements will be available on the Internet to provide HHS financial information to a broader audience and to increase the accessibility of our financial information. In addition to the goals and measures presented in the main body of this Five Year Plan, our corrective action plans for resolving internal control material weaknesses, and findings on financial systems are included in the appendices of this plan.

Performance Area 01 A 1: Financial Statement Audit Opinion

HHS prepared audited financial statements in FY 2000 for the Department and nine of its largest OPDIVs. They include: the Administration for Children and Families (ACF), Agency for Toxic Substances and Disease Registry (ATSDR), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), Health Care Financing Administration (HCFA), Indian Health Service (IHS), National Institutes of Health (NIH), Program Support Center (PSC), and the Substance Abuse and Mental Health Services Administration (SAMHSA). To avoid confusion among the various measures, CDC and ATSDR are counted as one OPDIV for all of the measures in this plan since ATSDR is included in CDC's financial statements.

In earning a clean opinion, HHS reduced the qualification on Medicare contractors accounts receivable to a material weakness. Also HHS eliminated the qualification related to the statements on custodial activity, budgetary resources, and financing. In addition to CDC and FDA, who achieved clean opinions in both FY 1998 and FY 1999, ACF, FDA, HRSA, HCFA, NIH, PSC and SAMHSA earned clean opinions for their FY 1999 statements.

Over the next five years, we plan to maintain clean audit opinions on all of these entities while reducing the number of material weaknesses and reportable conditions. The latest entity to have a full scope audit is Administration on Aging (AoA). The AoA has begun to prepare for financial statement audits covering FY 2001 and beyond. In FY 1999 AoA participated in pre-audit survey work, preparation of the management letter, systems documentation and training to ensure staff are fully trained in standards and requirements, and that management controls are in place. In FY 2000 they will have their balance sheet audited in preparation for a complete audit.

Performance Area 01 A 2: Auditor's Report on Internal Controls

For FY 2000 and beyond, our primary goal will be resolving all internal control material weaknesses and reportable conditions cited by auditors at both the department-wide and OPDIV levels during the audit process. While these material weaknesses and reportable conditions do not affect the outcome of the auditor's opinion (unless they are also cause/contribute to qualifications), they represent important operations and/or financial management issues which must be resolved. Note: The number of reportable conditions may temporarily increase as material weaknesses are downgraded.

Performance Area 01 A 3: Report on Compliance with Laws and Regulations

HHS has numerous financial management systems/applications, some of which are OPDIV-specific and others that are used for departmental or cross-servicing purposes. Our goals for those systems relate to customer access to information, compliance with laws, and consistency with accounting standards and policies.

Our most significant challenge and highest priority related to systems, is addressing the issues identified in the FFMIA Report. See Appendix F. Our performance in this area will be most comprehensively measured with respect to our compliance with the Federal Financial Management Improvement Act of 1996.

Although the non-compliance finding was removed and the error rate reached a plateau in FY 1999, HHS and HCFA will continue to track and work with health providers to reduce the Medicare error rate.

01_A_1_a Audit opinion is timely.

Annual Performance Targets

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Audited financial statements for HHS and HCFA are submitted to OMB by 3/1 as required by GMRA	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: No for the FY 1996 audited financial statements. More recently, the FY 1999 HHS and HCFA statements were submitted timely on 3/1. Other OPDIVs will submit their audited financial statements to OMB based on the agreed upon audit due dates.
(2) Number of OPDIV audited financial statements submitted by established milestone date	9 of 9 ACF, CDC, FDA, HCFA, HRSA, IHS, NIH, PSC, SAMHSA	10 of 10 AoA's first audit	10 of 10	10 of 10	10 of 10	10 of 10	Baseline: FY 1997 - zero were timely. More recently, in FY 1999, 8 of 9 OPDIV statements were timely based on mutual agreements of the parties. The key date is the completion of an audited financial statement.

01_A_1_b Receive a clean audit opinion.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Clean = Yes Other = No	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: No clean opinion on the Department's FY 1997 financial statements; there were 5 qualifications to the audit opinion. More recently, the FY 1998 audit resulted in a qualified opinion with 2 qualifications, and the FY 1999 statements were clean.
(2) Number of clean opinions reported by the OPDIVs	9 of 9 ACF, CDC, FDA, HCFA, HRSA, IHS, NIH, PSC, SAMHSA	10 of 10 (revised) AoA's first audit	10 of 10	10 of 10	10 of 10	10 of 10	Baseline: The audits of the OPDIV FY 1997 statements resulted in no clean opinions. More recently, the FY 1999 opinions for 8 of 9 audited OPDIV statements were clean. AoA is the 10th OPDIV who have a full audit beginning with its FY 2001 statements.

01_A_1_c Implement the cost accounting standard and use cost information in decision-making process.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of OPDIVs that identify expense types within GPRA programs	4	3 (revised) FDA, HCFA, and NIH	9 (revised) FDA, HCFA, NIH, CDC, and PSC-serviced OPDIVs	10	10	10	Baseline: FY 1999 – 2 OPDIVs (HCFA and FDA). This measure provides an additional level of information for a manager's decision-making. Targets were adjusted to reflect OPDIVs' submissions. FY 2000 and FY 2001 targets were corrected to reflect a delay from FY 2001 to FY 2002 for PSC-serviced customers.

01_A_2_a Have no material weaknesses.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of department-level material weaknesses	3 Financial Reporting, Medicare Accounts Receivable, and Medicare Electronic Data Processing	2 (revised) Resolve Financial Reporting	1 Reduce Medicare EDP	1	1	0 Resolve Medicare Accounts Receivable	Baseline: FY 1997 - 5 material weaknesses were cited in the HHS audit opinion. More recently, in FY 1999, the audit opinion cited only 3 instead of the targeted 5 material weaknesses. Material weaknesses are also considered resolved when improvements result in their reduction down to reportable conditions. HCFA is working to resolve two of the material weaknesses. The third material weakness is crosscutting among the OPDIVs so PSC and departmental action are needed to help resolve it.
(2) Number of OPDIV-level internal control material weaknesses	5 Financial Reporting, Medicare Accounts Receivable, Medicare EDP	2 (revised) Resolve Financial Reporting In 6 OPDIVs	1 (revised) Reduce Medicare EDP	1	1	0 Resolve Medicare Accounts Receivable	Baseline: FY 1997 - 21 OPDIV material weaknesses, some of which were crosscutting and have since been consolidated or resolved. More recently, in FY 1999, there were 8 material weaknesses identified in the OPDIV audit opinions; 6 of which were for financial reporting and 1 each were for Medicare accounts receivable and EDP. The ultimate goal is to reduce the number; however the number may initially increase as improvements are made to prior qualifications.

01_A_2_b Have no reportable conditions.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of department-level reportable conditions	3 (revised) Medicare Regional Office Oversight, Medicaid Error Rate, EDP	3 (revised)	2 (revised) Resolve Medicare Regional Oversight	2 (revised)	2 (revised)	2	Baseline: FY 1997 - 3 reportable conditions. More recently, in FY 1999, there were 4 reportable conditions including Property, Plant, and Equipment. This Property finding is expected to be resolved in FY 2000, so the FY 2000 target was revised from 5 to 3. Reportable conditions are identified in the HHS audit opinion and although they decreased at the department-level in FY 1999, they may increase, as material weaknesses are resolved.
(2) Number of OPDIV-level internal control reportable conditions	36 (revised) ACF-3, CDC-7, FDA-3, HRSA-5, HCFA-4, NIH-4, PSC-7, SAMHSA-3	15 (revised) ACF-3, CDC-5, HCFA-3, NIH-2, SAMHSA-2	9 (revised) ACF-3, HCFA-2, NIH-2 , SAMHSA-2	5 (revised) ACF-2, HCFA-2, SAMHSA-1	3 (revised) 1 ACF-1, HCFA-2	3 ACF-1, HCFA-2	Baseline: FY 1997-59 reportable conditions. More recently, in FY 1999, 47 reportable conditions were identified. The ultimate goal is to reduce the number of reportable conditions; however as improvements are made to qualifications and material weaknesses, the number may increase initially. A complete explanation of the reportable conditions is contained in each OPDIV audit opinion and in the OPDIV corrective action plan.

01_A_2_c Ensure that accountability and controls for Medicare contractor transactions exist.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Percentage of Medicare contractors that will be subjected to a SAS 70 (Type I and Type II)	20%	20%	20%	20%	20%	20%	Baseline: FY 2000 To be established. This is a new measure. Statement of Accounting Standard No 70 (SAS 70) is intended for all entities that outsource tasks for conducting accounting transactions and related services. It requires accountability and internal control assessments. Based on the results of the SAS 70s (Type I) performed in FY 2000, HCFA will continue SAS 70s of Medicare contractors using a more detailed approach (Type II). HCFA plans to review all Medicare contractors remaining in the program at least once in the five-year period.

01_A_3_a Have no instances of non-compliance with laws and regulations.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of department-level instances of non-compliance	1 (FFMIA)	1	1	1	1	1	Baseline: FY 1997 - 4 instances of non-compliance. More recently, in FY 1999, HHS had 1 non-compliance with the Federal Financial Management Improvement Act. See Appendix F for the HHS FFMIA corrective action plan. A detailed discussion of the findings is contained in the HHS audit report.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(2) Number of OPDIV-level instances of non-compliance	4 (FFMIA)	3	3	2	2	2	Baseline: FY 1998 - 8 instances of non-compliance. More recently, in FY 1999, there were also 8 instances. The majority of the instances related to compliance with the FFMIA.
(3) Percent of improper Medicare Fee-for-Service payments	7% (revised)	6%	5%	5%	5%	5%	Baseline: FY 1996 - Non-Compliance with the Social Security Act; the estimated error rate was 14%. More recently, in FY 1999, the estimate was 7.97% and the non-compliance finding was removed. Providers need to maintain medical records that contain sufficient documentation and to use proper procedure codes when billing Medicare for services. Improper claims for payment could range from inadvertent mistakes to outright fraud and abuse; the portion attributable to fraud cannot be quantified. Improper payment error rates are identified in the Inspector General's annual audits of the fee-for-service payments.

Strategy 01 B: Improving, Enhancing, and Integrating Financial Management Information.

During the last decade, the pressure to keep up with the rapid advancements in technology has changed how both the public and the private sector does business. The impact of technology on systems, communications, and human resources has shaped the way business and decision making is conducted. The Federal government faces additional challenges in the need to balance its public responsibility with efficient business-like approaches and also promote its ability to compete. In response to these challenges, the HHS CFO organizations are continually seeking better methods and processes that address the needs of decision-makers and program managers and improve the management of government resources.

Performance Area 01 B 1: Optimizing Financial and Other Management Information for Decision-Makers

HHS fully supports the concept of the Accountability Report as envisioned by the United States CFO Council and has committed to the production of its department-wide audited financial statements within the framework of an Accountability Report. It is our intent to be fully accountable to the taxpayers for the billions of dollars entrusted to us and to report this information to the public and Congress on an annual basis in the Department's annual Accountability Report. HHS produced its first Accountability Report covering FY 1996, and officially joined the streamlining pilot project for financial and management reports with its Accountability Report covering FY 1997.

HHS OPDIVs are also being encouraged to move toward production of their own "mini" Accountability Reports as they prepare their own audited financial statement reports. HCFA, CDC, FDA, HRSA, ACF, and SAMHSA have already begun or continued to move in this direction with their FY 1999 reports.

HHS also prepares other external reports (such as the Federal Agencies Centralized Trial Balance System (FACTS I) submission, the Treasury Report on Receivables (Schedule 9), the Financial Management Service 2108 Year-End Closing Statement, and the SF 133 Report on Budget Execution. (The last two reports are now included in FACTS II)) These are used by decision-makers for various purposes. It is our intention to improve the timeliness and accuracy of these reports, and we have developed measures in that regard.

Additionally, we believe that internal reports can be developed from our financial systems with data that could help management improve its services, efficiencies, and costs much the way internal reporting in the private sector is used. Our financial managers will be working with program managers to develop reports that could help identify and analyze information, which could lead to decisions based on better information than is currently available.

Performance Area 01 B 2: Expanding Our Financial Systems Capability

As HHS moves forward in Electronic Government (E-Gov), we are assessing our current status and are addressing the demand for on-line government interaction and simplified, standardized ways to access government information and services. Our financial objective is to have automated financial systems that provide complete and useful financial information and support preparation of HHS' financial statements**.**

HHS continues to comply with government-wide requirements to develop integrated financial systems. HHS financial systems rely heavily on departmental standards and procedures to ensure that the financial data is accurate and complete and also to ensure that HHS satisfies government-wide requirements such as Federal Accounting Standards Advisory Board (FASAB), the CFO Act, and the FFMIA of 1996. The Department's Office of Finance (OF) sets the policy to accomplish this objective.

Several of HHS' OPDIVs are currently anticipating upgrades to their core accounting systems. Through the OF leadership, workgroups have been established to develop evolving, effective policy and methodology to address systems requirements. Also, HHS is represented on government-wide CFO Council committees and sub-committees, and other government-wide committees, to assist in the development of government-wide policy and ensure that HHS is an active participant in financial systems changes. Consolidation of systems, such as the replacement of the Health Accounting System with the former Office of the Secretary (OS) CORE accounting system, and the replacement of legacy systems, remains a departmental priority. In the systems area, there are several department-wide and/or cross-servicing systems issues to be addressed.

For the long term, we hope to implement software that can interface with improved OPDIV systems and eliminate the need for re-keying OPDIV financial statement information for the Department's consolidated financial statements. This software will also allow for more timely periodic financial reports and on-line access to special reports for managers.

We also want to ensure that the information on our grants systems is accessible to those who need it; that systems under development are proceeding on time and on budget, and that we have identified our data and systems needs as we move into a more performance-oriented culture. The same types of concerns are applicable at the OPDIV level. Each OPDIV operates one or more electronic grant management information system(s) to award the grants under their programs.

HHS is actively participating in the InterAgency Electronic Grants Committee's (IAEGC) Federal Commons project. This effort directly benefits every Federal agency involved in making grants to a variety of recipients, including state and local

governments, tribes, universities, research institutions, non-profit organizations, and others. The Federal Commons provides a single point and "common face" for sending and retrieving grant applications, awards, and other information.

The Department also has implemented a Tracking Accountability in Government Grants System (TAGGS) as a central repository for grants data generated by every OPDIV. TAGGS is used as a department-wide grants management information system and an executive tool for responding quickly and comprehensively to requests for grants information.

Performance Area 01 B 3: Developing and Disseminating Policy Guidance and Related Information Impacting Financial Management

Timely, accessible and collaborative policies enable sound financial management decision-making.

HHS issues financial management policy to ensure consistency across the Department while allowing for flexibility at the OPDIV level. The HHS Financial Policy Group provides a vehicle for participation of the HHS OPDIVs in the formulation of policy. The OPDIVs, such as the AoA, have their own Financial Policy Group to ensure consistency. In addition, AoA's CFO has also consolidated all financial policy guidance within the office of the CFO.

Information technology is an essential tool at HHS for effective policy-making and efficient communication within the HHS financial management community. The Administration for Children and Families (ACF) and the National Institutes of Health (NIH), are examples of OPDIVs that use information technology to provide easier, more timely access to information and enhance communication.

We have developed goals for measuring our effectiveness at developing and disseminating policy guidance within the Department e.g., information dealing with the Departmental Accounting Manual.

Also, the HHS Travel Manual is in need of review, reformatting, and updating from its 1988 issuance due to changing regulations and HHS travelers' needs. During FY 2000, HHS established a Travel Page on the HHS Intranet to assist HHS travelers. This site links Federal Travel Regulations and includes HHS travel policy guidance.

01_B_1_a Submit a timely Accountability Report.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Submit Accountability Report to OMB by March 1	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: FY 1997 Not timely. More recently, for the FY 1999 period, the report was timely.
(2) Number of OPDIVs who submit their Accountability or Financial Reports by due date	9 of 9	10 of 10	10 of 10	10 of 10	10 of 10	10 of 10	Baseline: FY 1998 8 of 8 were timely. More recently, for FY 1999 reports, 8 of 9 were timely. OPDIV overviews must be submitted to the auditors and to HHS so the HHS and government-wide audited financial statements/overviews will be on time.

01_B_1_b Provide useful internal reports for program managers.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of OPDIV systems with useful internal reports that include cost information for individual programs	4 (HCFA, HRSA, NIH, PSC)	5 (FDA, HCFA, HRSA, NIH, PSC)	5	5	5	5	Baseline: To be determined. Monthly financial reports assist decision-makers throughout the year. Reports should tell program managers and other managers the actual costs of programs in a timely manner. The content of the reports will vary, depending on the needs of the user. While HHS systems are capable of producing cost information, this information has to be tailored to the needs of individual programs and linked to their GPRA performance. HHS will work with OPDIVs to establish strategies for accommodating these individual needs.

01_B_1_c Improve the timeliness and accuracy of external Financial Reports.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) President's Budget reflects final figures from FACTS II	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: FY 1999 5 OPDIVs (ACF,CDC, FDA, HCFA, NIH). The target of Yes indicates that all OPDIVs and HHS as a whole will have budget execution and year-end closing statement information that is consistent with the President's budget.
(2) Number of year-end Treasury Reports on Receivables (TROR) made to Treasury by 11/15	18	18	18	18	18	18	Baseline: FY 1999 - 5 OPDIVs (ACF, FDA, PSC, HCFA, and SAMHSA). Treasury requires year-end data within 45 days of the end of the fiscal year. Several OPDIVs submit multiple reports.
(3) Budget Execution data is submitted timely and accurately each quarter in accordance with Treasury's schedule guidelines	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: FY 1999: 4 (CDC, FDA, NIH, and HCFA). The Yes indicates that all OPDIVs are submitting their data timely and accurately. OPDIVs are required to submit reports on 100% of their accounts to Treasury.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(4) Receive the Association of Government Accountant's Certificate of Excellence on Accountability Reporting	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: FY 1999 Prepared report using the CEAR checklist and submitted application. This certification indicates that the report is a useful tool for decision-making. Results may not be available until after publication of this document.

01_B_2_a **All department wide and cross-servicing systems are readily accessible by customers, provide needed information, are developed and implemented in an appropriate fashion, and will be fully functional in the years ahead.**

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/ Comments:
(1)(a) Percentage of OPDIVs providing grants data to Tracking Accountability in Government Grants System (TAGGS)	100% (12 of 12)	100%	100%	100%	100%	100%	Baseline: FY 1998: 83% (10 of 12 OPDIVs). More recently, in FY 1999, all 12 OPDIVs provided data to TAGGS. OPDIVs are responsible for providing the data on their grant-making activities on a continuing basis.
(1)(b) Department participates in the interagency Federal Commons Project		Participate in development and completion of interagency project plan.	Complete implementation of initial project modules.	TBD	TBD	TBD	Baseline: FY 2001 – To be determined. This is a new measure.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(2)(a) Payment Management System (PMS) stage of development and implementation	In production beginning of 4th quarter	Operational	Operational	Operational	Operational	Operational	This is a PSC System that makes grant payments for HHS and other agencies.
(2)(b) Financial Assistance Reporting System (FARS) stage of implementation	New system under development	Operational in 2nd quarter	Operational	Operational	Operational	Operational	This is a PSC system that provides a report on federal assistance obligations by geographic area.
(2)(c) FED-HR-21 stage of implementation	Tasks 1-3 were completed in FY 1999. No further tasks are planned for this system.	Operational	Operational	Operational	Operational	Operational	This is a PSC system. Implementation was completed in FY 1999.

01_B_2_b All OPDIV systems are readily accessible by customers, provide needed information, are developed and implemented in an appropriate fashion, and will be fully functional in the years ahead.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Develop e-business systems targets and track the department-wide implementation of electronic commerce	Develop targets	Begin to track targets	Track	Track	Track	Track	Baseline: Develop in FY 2000. This is a new measure. The measure indicates the degree of implementation of HHS electronic commerce.

1_B_3_a Departmental guidance and related information is appropriately developed and publicized.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1)(a) Percent of Department Accounting Manual (DAM) chapters on the Internet	46% 24 of 52	100% (revised) 52 of 52	100% (revised) 52 of 52	100% (revised) 52 of 52	52 of 52	52 of 52	Baseline: FY 1998 – 18.2% of DAM pages were on the Internet. More recently, in FY 2000, 100% of the chapters were on the Internet, therefore the targets for FY 2001-2003 were adjusted upward. As chapters are revised and updated, the size of the DAM will change.
(1)(b) Percent of DAM chapters on the Internet that are current (not needing updates)	46%	55%	65%	75%	85%	95%	Baseline: FY 2000 – To be developed. This is a new measure. The percent is based on the current 52 DAM chapters.
(1)(c) Number of HHS financial policy guidance issuances posted to the HHS Intranet	100%	100%	100%	100%	100%	100%	Baseline: FY 1999 None. Basis for measure/targets: Number of policies posted based on procedures established and published by the HHS Office of Finance.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(2)(a) Percent of Grants Administrative policies available on the HHS Intranet and Internet	100%	100%	100%	100%	100%	100%	Baseline: FY 1998: 70%. More recently, in FY 1999, 100% of grant policies were accessible via the Internet/Intranet. The measure and target are based on the total number of grant administrative polices divided by the number of those on the HHS Internet/Intranet.
(2)(b) Percent of grant administration policies that are current	93% (revised)	100%	100%	100%	100%	100%	Baseline: FY 1998: 75%. More recently, in FY 1999, 85% of the guidance was current. This is determined by the average of the percent of Grants Administration Manual chapters replaced by succinct, updated guidance in Grants Policy Directives (GPDs) and the percent of GPDs requiring reevaluation for reissuance on a standard review cycle.
(3) Percent of HHS Travel Manual Chapters (domestic) updated and posted on the HHS Internet	3%	39%	68%	100%	100%	100%	Baseline: FY 1999 - 0%. This is a new measure. There are 28 Travel Manual chapters that have to be reviewed and updated. One new chapter has been issued in FY 2000 regarding the Travel and Transportation Reform Act of 1998. Drafts of 7 other chapters have been sent out for comment already in FY 2000 and are expected to be issued in early FY 2001.

STRATEGIC GOAL 2:

ALL RESOURCES ARE USED APPROPRIATELY, EFFICIENTLY AND EFFECTIVELY

Goal 2: All Resources are Used Appropriately, Efficiently, and Effectively.

Resources approximating 21% of Federal net outlays were expended by HHS in FY 1999, and that percentage is expected to grow. It is the responsibility of all HHS managers to ensure that those resources are used appropriately, efficiently, and effectively. To do so, HHS will strengthen its business practices and internal controls, improve our management of physical assets and capital investments, and work to develop and maintain a skilled and motivated financial management staff.

Strategy 02 A: Strengthening Our Business Practices

Electronic Government (E-Gov) is the electronic exchange of information and services between government entities and stakeholders. One principal purpose and component of E-Gov is E-Commerce (EC). E-Commerce is the paperless electronic exchange of business information. Electronic techniques include electronic mail or messaging, World Wide Web technology, electronic bulletin boards, purchase cards, electronic funds transfer, and electronic data interchange.

Under the Office of Federal Procurement Policy Act (OFPP Act) and the Information Technology Management Reform Act (ITMRA), OMB is required to provide a yearly report to Congress on the Federal agencies' implementation of Electronic Commerce in their acquisition activities. In preparation for this report, agencies are required to specifically link initiatives to the strategic actions that are detailed in the previously submitted government-wide strategic plan. The current building blocks include: improving internal management structures, using electronic catalogs and electronic payments, improving access to business opportunities (contracting), and implementing contract writing systems.

The agencies are also required to establish milestones and performance measures as well as budget cross- references for major initiatives. Additionally, agencies must plan and document the cross-functional management approach used in the implementation of electronic commerce. For this purpose, a department-wide committee composed of OPDIV Executive Officers and departmental representatives from finance, information resources management, logistics and acquisitions has been established to oversee these efforts. HHS is also preparing operating plans for coming into compliance with the government Paperwork Elimination Act (GPEA), a recent act that requires governmental use of electronic interface with the public by 2003. The plans are due in October 2000.

Collection of debts owed to HHS is also an important aspect of sound financial management and business practice. HHS will continue to focus on increasing collections as part of its compliance with the Debt Collection Improvement Act (DCIA).

Performance Area 02 A 1: Timely Payments, Reimbursements, and Collections

We have developed goals and measures to help us track the timely payment of bills (to avoid late fees and interest penalties), to reduce paperwork and facilitate reconciliation processes by taking advantage of technology with electronic funds transfer (EFT) and credit cards, and to improve collection procedures for monies that are owed to HHS and custodial parents. New and enhanced automated financial systems, as well as streamlined processes (e.g., increased use of credit cards), have aided OPDIVs such as AHRQ in this endeavor. Travel expenditures of Federal employees are in many cases directly visible to the American public and as such must especially avoid any appearance of fraud, waste or abuse.

Many Federal travelers do not travel on a frequent basis, so it is important that they are aware of the constraints and are accountable for proper expenditures. The Travel and Transportation Reform Act of 1998 and related Federal Travel Regulations require agencies to reimburse employees within 30 calendar days after submission of a proper travel claim to the agency's designated approving office or to pay a late payment fee. This requirement became effective in HHS during the middle of FY 2000. The Department is setting performance targets for timely temporary duty travel voucher and travel card payments to promote compliance with the law and to identify any problem areas.

Performance Area 02 A 2: Effective Grant, Acquisition, and Logistics Management

As the largest grant-making organization in the Federal Government (accounting for almost 60% of Federal grant dollars), HHS must manage its grant-making functions well so that the recipients of the grants will have the intended benefits of the grants.

HHS also has significant investments in acquisitions and logistics activities that support HHS programs. Objective assessments are used to determine how effectively these three functions are being managed.

For example, HHS has worked closely with the OPDIVs to develop an Acquisition Performance Measurement and Improvement System (also known as the Acquisition Balanced Scorecard). Procurement offices throughout the HHS use the balanced scorecard measurement system to assess procurement performance and improve the delivery of acquisition services. The Acquisition Balanced Scorecard measures performance factors such as timeliness, quality, service-partnership, efficiency and executive leadership. The scorecard provides balance in assessing acquisition performance by surveying stakeholders such as customers, contractors, and employees. Composite Scorecard results will help HHS gauge the overall health of its acquisition function.

02_A_1_a Pay over 95% of vendor payments on time.

Annual Performance Targets

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Percent of vendor payments made on time	95%	95%	95%	95%	95%	95%	Baseline: FY 1998: 91%. More recently, in FY 1999, 96.4% was achieved. Because of the volume of their activities, NIH and PSC are the OPDIVs that have a critical impact on meeting these targets. This year NIH has reduced its targets to 93% from 95% for the outyears beginning in FY 2001 to reflect current performance levels. However, the PSC has committed to 95% for all years so the HHS targets will remain at the 95% target level established by OMB.

02_A_1_b Increase percent of payments made via Electronic Funds Transfer.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Grant Payments	100%	100%	100%	100%	100%	100%	Baseline: FY 1997: 100%. More recently, in FY 1999 we also achieved 100%. The PSC makes the grant payments for the OPDIVs. Treasury guidelines issued in January, 1999 established conversion targets of 69% and 75% respectively for FY 1999 and 2000, which HHS exceeded. Treasury targets have not yet been established for future years. HHS will continue to work to maintain100%.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(2) Salary Payments	100%	100%	100%	100%	100%	100%	Baseline: FY 1997: 98%. More recently, the FY 1999 figure for timely payments was 99%. The PSC makes the salary payments for the OPDIVs. Treasury guidelines issued in January 1999 established conversion targets of 69% and 75% respectively for FY1999 and 2000, which HHS exceeded. Targets have not yet been established for future years. HHS will continue to work to reach 100%.
(3) Travel Payments	75% (revised)	100%	100%	100%	100%	100%	Baseline: FY 1997: 43%. More recently, EFT travel payments in FY 1999 reached 93%. Treasury guidelines issued in January 1999 established conversion targets of 69% and 75% for FY 1999 and FY 2000,respectively. HHS will continue to work to exceed these targets. PSC provides travel payment services for all OPDIVs except CDC, FDA, HCFA, and NIH.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(4) Vendor Payments	85%	90%	95%	95%	100%	100%	Baseline: FY 1997: 42%. More recently, EFT vendor payments in FY 1999 reached 85%. For vendor payments, PSC is committing to targets progressively increasing from 80% to 90% for the OPDIVs for which it makes payments. CDC, FDA, HCFA and NIH have responsibility for their own vendor payments. Treasury guidelines issued in January 1999 established conversion targets of 69% and 75% for FY 1999 and 2000 respectively. Targets have not yet been established for future years. HHS will continue to work to exceed these targets.

02_A_1_c Increase the timeliness of travel payments

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/ Comments:
(1) Timely payment of approved travel vouchers within 30 calendar days of submission to first-level reviewing official	93% (May - September)	95%	95%	96%	96%	96%	Baseline: FY 2000 – To be developed. This is a new measure. Effective FY 2000, federal agencies are required to pay proper travel vouchers within 30 calendar days or pay a late payment fee to the employee.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/ Comments:
(2) Percent of individually billed travel accounts that are past due 60 or more days	17.6%	15%	13%	11%	10%	10%	Baseline: FY 2000 – To be developed. This is a new measure. Employees are responsible for paying their travel card bills timely. HHS OPDIVs can influence this statistic by paying proper travel vouchers timely and by educating their employees about travel card responsibilities.
(3) Percent of centrally billed travel accounts that are past due 60 or more days	12.6%	10%	8%	6%	5%	4%	Baseline: FY 2000 – To be developed. This is a new measure. The target is to pay bills timely and reach 0% as soon as possible.

02_A_1_d Increase the dollar amount of purchases via credit cards.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Percentage of eligible purchase transactions made on credit cards	85%	87%	89%	91%	91%	91%	Baseline: FY 1997: 77% of 500,000 transactions. More recently, in FY 1999 85% of the eligible transactions were made by purchase card. Basis for measure/targets: The percent of eligible transactions is determined by the ratio of purchase transactions made under $2,500 using credit cards to the total purchases under $25,000. The targets reflect projected rates of growth in credit card use. Eligible transactions do not include the NIH DELPRO transactions, which are another means of paperless electronic ordering and payment.

02_A_1_e Improve the collection of debt owed to us.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Increase percent of collections over prior year	10% increase ($15.7 billion)	10% increase	10% increase	10% increase	10% increase	10% increase	Baseline: FY 1998: $13.3 billion. More recently, in FY 1999, $14.27 billion in debts was collected. Basis for measure/target: The target is to have an increase of 10% in total dollars collected over the prior year (The FY 2000 target of $15.7 billion is 10% more than $14.27 billion collected in FY 1999). HCFA's performance is critical to achieving this target and has committed to this increase.

02_A_1_f Improve the collection of delinquent debt to us.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Percent of eligible non-waived delinquent debt referred for cross-servicing to Treasury	100%	100%	100%	100%	100%	100%	Baseline: FY 1998: 0% referred as we were anticipating designation as a government-wide Debt Collection Center. More recently, in FY 1999, 22.8% of eligible debt was referred to Treasury for cross-servicing. Targets of 100% are in accordance with law (DCIA of 1996). HCFA is a key OPDIV in achieving these targets. HCFA's FY 2000 target of 70% is based on the debt eligible for referral as of September 30, 1999. HCFA's use of FY 1999 data as the basis is consistent with targets and goals provided to the Department of Treasury.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(2) Percent of eligible waived delinquent debt referred to PSC for cross-servicing	100%	100%	100%	100%	100%	100%	Baseline. FY 1999: 3.7%. PSC received approval in January 1999 to act as a debt collection center for certain debts. The target is in accordance with law (DCIA of 1996). Baseline and targets are actual dollars referred as a percentage of eligible dollars. HCFA is a key OPDIV in achieving these targets. HCFA's FY 2000 target of 27% is based on the debt eligible for referral as of September 30, 1999. Using FY 1999 as the base is consistent with targets and goals provided to the Department of Treasury.
(3) Percent of eligible delinquent debt referred to the Department of the Treasury for offset	100%	100%	100%	100%	100%	100%	Baseline: FY 1998: 20.2% (2nd quarter baseline established in FY 1998 Plan). More recently, in FY 1999, 10.5% was referred to Treasury. Targets of 100% are in accordance with law (DCIA of 1996). Baseline and targets are actual dollars referred as a percentage of eligible dollars. HCFA is a key OPDIV in meeting these targets. HCFA established the FY 2000 target at $1.5 billion, which is 40% of HCFA's debt eligible as of September 30, 1999. OMB, HHS, and Treasury agreed to this target.

02_A_1_g Improve the collection of child support payments.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Increase the dollars for child support collections over prior year	$17.0 billion (revised)	$18.524 billion (revised)	$20.041 billion (revised)	$21.686 billion (revised)	$23.371 billion (revised)	$24.794 billion	Baseline: FY 1998: $14.367 billion as of May 1999. Targets for total dollars collected represent a 6-8.9% increase above the prior year. There was a slight decrease in the targets for all years as a result of a 5.8% decrease in TANF collections that were most likely due to the decreasing TANF caseload. Also States collect the funds and they are implementing new data reliability audits that will help to refine the accuracy of reporting.

02_A_2_a Increase the effectiveness of the departmental policies for grants, procurement, and logistics.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Results of the departmental biannual surveys of the OPDIV customers	3.9 rating	Not applicable	4.2 rating	Not applicable	4.5 rating	Not applicable	Baseline: FY 1998: 3.4 of 5. The Department developed a survey instrument in FY 1998 that measures effectiveness of its functional management. A survey of FY 1998 performance was the first performed. Surveys will be conducted once every two years to allow for organizational improvements to take effect between surveys. One question relates to effectiveness of departmental grant, procurement and logistics policies. The assessment of FY 2000 performance will be conducted in FY 2001.

02_A_2_b Improve Acquisition Management throughout HHS.

HHS	FY 2000 Baseline	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
Composite Acquisition Balanced Scorecard results						.	Baseline: Established in FY 2000. Due to a major systems upgrade, earlier survey results and FY 2000 and FY 2001 targets are no longer applicable. Acquisition Balanced Scorecard surveys are conducted every two years. Thus, performance targets are aligned to that two-year cycle.
(1)(a) Customer satisfaction	83.29%	Not applicable	87.4%	Not applicable	89.1%	Not applicable	
(1)(b) Employee satisfaction	72.19%	Not applicable	75.7%	Not applicable	77.2%	Not applicable	
(1)(c) Vendor satisfaction	80.9%	Not applicable	84.9%	Not applicable	86.6%	Not applicable	

Strategy 02 B: Improving Physical Asset Management

Not only must HHS properly manage its cash assets, but also its physical assets. HHS' physical assets include NIH research equipment, IHS health service facilities, and the Department's computer information systems, to name a few. We have developed measures to help us comply with new capital asset planning guidance so that major systems are approved by an objective process headed by the Information Technology Investment Review Board. We have also developed measures to quantify our progress in managing physical property and property financial records.

Performance Area 02 B 1: Capital Asset Planning

Capital asset planning improves project management and promotes cost effective use of resources. OMB Circular A-11, Part III prescribes the requirements for capital asset planning and the content of the budget exhibits used to justify the funding of the asset. OMB identifies the capital assets, which require planning and reporting in the budget submission each year; the identified assets vary each year. Capital assets include land, structures, equipment and intellectual property, including software that are used by the Federal government and have an estimated useful life of two years or more.

Performance Area 02 B 2: Property and Inventory Valuation, Location and Conservation

Property values in the general ledger and property records must reconcile. In addition, the location of the property identified in the property records must be accurate. Wall-to-wall inventories such as the one conducted at NIH in FY 1998 and FY 1999 greatly contribute to better asset management and removal of negative audit findings.

Management of real property assets also impacts the financial condition of HHS. One major element of real property management that is receiving a lot of the Administration's attention is energy conservation. Executive Order 13123 mandates that Federal agencies decrease their energy consumption and provides percentage reduction goals. By reducing energy consumption, HHS not only helps to conserve natural resources, but also reduces the costs of operation.

02_B_1_a Fully comply with capital asset planning requirements.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Identified OPDIVs submit fully compliant A-11, part 3 exhibits in their budget submissions.	5 OPDIVs FDA, NIH, IHS, HCFA, CDC	7 OPDIVs ACF, CDC, FDA, HRSA, HCFA, NIH, and PSC	100% Comply	100% Comply	100% Comply	100% Comply	Baseline: FY 1998: 3 OPDIVS (FDA, NIH and IHS complied). OMB identifies which OPDIVs must submit the capital asset planning analysis with the Budget OMB Circular A-11, Part 3 identifies the procedures and data to be provided.

02_B_1_b OPDIVs establish IT architectures and an investment analysis/capital planning process to facilitate selection of IT initiatives.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of OPDIVs with established IT architecture and investment analysis/capital planning processes	8	8	8	8	8	8	Baseline: FY 1998: ACF and NIH. More recently, in FY 1999, 6 OPDIVs had established IT architectures and capital asset planning processes. The Information Technology Management Reform Act requires that investment analysis processes be developed for acquisition and management of IT. AHRQ, ACF, CDC, FDA, HRSA, HCFA, NIH, and PSC are included in the FY 2000 target.

02_B_1_c Departmental Information Technology Review Board process assures soundness of information technology capital investments.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) 100% of IT investments approved by the ITIRB meet review criteria	100%	100%	100%	100%	100%	100%	Baseline: FY 1999: 3 meetings were held. All investments either met the requirements or were brought into compliance through Board action. Investments approved by the ITIRB must meet the review criteria of OMB Memorandum M-97-02. Requests for investments must essentially comply with the criteria.

02_B_2_a Personal property records are accurate.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Location accuracy of capitalized personal property records	94%	96% (revised)	96%	96%	96%	96%	Baseline: FY 1998: 90%. More recently, in FY 1999 and FY 2000, a 97% accuracy rate was achieved. The FY 2001 target was increased to reflect this improvement. The targets for future years reflect the realistic level of accuracy that is recognized in HHS policy.

02_B_2_b Energy is conserved by HHS facilities.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/ Comments:
(2)(a) Reduction of energy consumption at HHS standard office facilities	16.5% below baseline	18%	19%	20%	21%	23%	Baseline: FY 1985 - 85 million British Thermal Units (BTUs) for office space. This is a new measure. The target % represents the remaining decrease in energy consumption per year that we expect to obtain in our effort to reach the FY 2005 mandated target of 30% for office space.
(2)(b) Reduction of energy consumption at HHS energy intensive facilities.	18.7% below baseline	20%	20%	20%	20%	20%	Baseline: 1990-373.4 million BTUs for lab/industrial space. This is a new measure. The target % represents the decrease in energy consumption per year that we expect to obtain in our effort to reach the FY 2005 mandated industrial and laboratory usage target of 20%.

Strategy 02 C: Strengthening Internal Controls.

The prevention and elimination of financial losses attributable to fraud, abuse and waste remain the primary objectives of HHS management control efforts. HHS' commitment to and progress in achieving this fundamental objective is most apparent for the Medicare and Medicaid programs. The success of the Health Care Fraud and Abuse Control Program is well documented, as is the commitment of the President and Congress to realize the success of that initiative nationally. Still, for Medicare and Medicaid, and all HHS programs, much more can be done to protect Federal resources from fraud, abuse and waste.

HS' approach to improving management control and audit follow-up focuses on integration and coordination. These management accountability programs must be integrated fully into financial and program management to ensure its success, and HHS financial and program managers must work closely with the Office of Inspector General (OIG) to ensure coordinated identification and resolution of management problems and deficiencies. The Department's efforts to improve the efficiency and effectiveness of HHS management accountability programs will continue to focus on integrating FMFIA and audit follow-up functions with other management accountability programs including GPRA reporting. HHS continues to incorporate FMFIA and audit follow-up information directly into HHS annual accountability reports.

Performance Area 02 C1: Federal Managers' Financial Integrity

Under the Federal Managers' Financial Integrity Act (FFMIA), HHS managers will continue to assess and provide assurances on management controls. HHS is committed to resolving material weaknesses, material non-conformances (of systems), and reportable conditions, as reflected in our measures.

Performance Area 02 C 2: Paperwork Reduction

The Paperwork Reduction Act of 1995 (PRA) requires that HHS minimize paperwork burden on the public and ensure the greatest public benefit from the use of information. In accordance with the requirements of PRA, OMB is setting a government-wide goal of 5% of the FY 1999 total burden. To achieve this target, HHS is working to balance the need to reduce data collection while new legislative requirements create the need for more data collection.

Performance Area 02 C 3: Budget Execution

Budget execution encompasses the control, review, inspection, and reconciliation of documents that obligate funds, and the revision of financial plans during the fiscal year to ensure the effective management of Federal programs and avoidance of

violations. The Budget Execution process begins with the enactment by Congress of an appropriation or a Continuing Resolution (CR), providing funding for one year or in the case of a CR, for a specified period of time. Since the accuracy of our outlay estimates is crucial in helping Treasury determine borrowing needs to cover cash flow and to properly allocate scarce budget authority during the development of the President's Budget, the Department has established a department-wide goal of +/-1% variance of actual outlays to estimates.

Since approval of apportionments is the first critical step in obligating federal resources, timely processing of apportionments is therefore a high priority in the Department's goal of efficiently allocating and using resources. Accordingly, we have developed department-wide goals for the timeliness of apportionment approval.

Performance Area 02 C 4: Electronic Data Processing Controls

HHS recognizes an increase in the need to protect the security of information technology systems and their data as the widespread transmission of information over the network increases. It is vital that HHS protects against unwarranted interruption of operations, to assure the integrity and privacy of automated information, and to protect against the potential for fraud, waste, and abuse.

Performance Area 02 C 5: Federal Financial Assistance Audit Resolution

Timely resolution of audit findings is important to HHS as well as the grantee and contractor organizations audited. The IG audit recommendations are to be addressed or resolved within six months after the audit findings are issued. For the most part, OPDIVs also complete final actions on IG reports, including collecting disallowed costs and carrying out corrective action plans, within a reasonable amount of time. However, HHS continues to monitor this area to improve procedures and assure compliance with corrective action plans.

02_C_1_a Resolve prior year FMFIA Section 2 material weaknesses and Section 4 non-conformances in a timely manner.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of Department level FMFIA material weaknesses pending at year end	6 (revised)	6 (revised)	TBD	TBD	TBD	TBD	Baseline: FY 1997: 7. More recently in FY1999, 6 material weaknesses were pending; FY 2000 and 2001 targets were revised as a result. OPDIVs identify management material weaknesses and prepare a corrective action plan to resolve them. These targets reflect the plans. Each OPDIV determines when a material weakness has been resolved. HHS determines which weaknesses warrant reporting to OMB.

02_C_2_a Reduce, minimize, and control burdens placed on the public by HHS and OPDIV information collections.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Percent of reduced burden hours imposed on the public by the HHS information collection inventory	5% reduction from FY 1999 base.	5% reduction from prior year.	5%	TBD	TBD	TBD	Baseline: FY 1999 +7.7% an increase of burden hours for the public. This measure is based on the percent change from the prior year in the number of public burden hours needed to comply with HHS regulations for data collection and retention. These burden hours are identified in requests for clearance of collection of information from the public that were approved by HHS and OMB. Accomplishment of these targets is affected by new and continuing legislation.

02_C_3_a Increase the accuracy of budget outlay estimates.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Amount of outlay variance compared with outlay estimate	+/- 1.0%	+/- 1.0%	+/- 1.0%	+/- 1.0%	+/- 1.0%	+/-1.0%	Baseline: FY 1997: 1.7%. More recently, in FY 1999 the variance was -2.90%. Basis for measure/targets is the difference between the outlay estimates in the HHS July A-34 Outlay Report and the actual outlays reported in Treasury's published U.S. Government Annual Report Appendix. Medicare and Medicaid larger variances impact the Department's total, however HHS will still work toward meeting the overall target of +/-1.0%.

02_C_3_b Improve the timeliness of apportionments processed.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Percentage of apportionments approved within 3 weeks	75% (revised)	75% (revised)	75% (revised)	75% revised)	75% (revised)	75% (revised)	Baseline: FY 1997: 46%. More recently in FY 1999, HHS achieved a rate of 76.60%. As a result, the targets for outyears were revised upward. Once apportionments are received by OS from the OPDIVs/STAFFDIVs, they are reviewed by OS Budget and Finance staff for submission to OMB. Apportionment documents are analyzed and approved by OMB. This means that OPDIVs, HHS, and OMB must work together and submit/approve information timely to meet the target of 3 weeks.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(2) Percentage of apportionments approved within 4 weeks	90% (revised)	90% (revised)	93% (revised)	95%	95%	95%	Baseline: FY 1997: 70%. More recently in FY 1999, HHS achieved a rate of 91%. Consequently, targets for FY 2000-2002 have been revised upward. Once apportionments are received by OS from the OPDIVs/STAFFDIVs, they are reviewed by OS Budget and Finance staff for submission to OMB. Apportionment documents are analyzed and approved by OMB. This means that OPDIVs, HHS, and OMB must work together and submit/approve information timely to meet the target of 4 weeks.

02_C_4_a Ensure that 100% of EDP material weaknesses and reportable conditions are resolved.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of departmental level EDP material weaknesses	1	1	0	0	0	0	Baseline: FY 1997 - 1 for EDP controls. More recently, in FY 1999, a repeat finding was received for Medicare contractors and HCFA's central office systems access and control. See Appendices B, C, and F.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(2) Number of departmental-level EDP reportable conditions	1	1	1	1	1	1	Baseline: 0 cited in the FY 1997 financial statement audit. More recently, 1 was cited in the FY 1999 financial statement audit. This finding was primarily due to systems access issues for department-wide, NIH, and FDA systems. See Appendices B and F.
(3) Number of OPDIV level EDP material weaknesses.	1	1	0	0	0	0	Baseline: FY 1998 audit: 1. More recently, in FY 1999, HCFA's Medicare Contractors and HCFA's Central Office received a finding on systems access and application control problems. HCFA expects to reduce this material weakness to a reportable condition in FY 2001. See Appendices B and F.
(4) Number of OPDIVs with EDP reportable conditions	7	5	3	2	1	1	Baseline: FY 1998 audit: 7 OPDIVs with reportable conditions. See Appendix B.

02_C_5_a Improve the average time for resolving grantee and contractor audits.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Reduction of average time for resolution of audits compared with prior year	3%	3%	TBD	TBD	TBD	TBD	Baseline: FY 1998 151 days average. More recently, in FY 1999 an average resolution period was reduced to 113 days. This success was a result of enhancements to the audit tracking system that now tracks and documents the average time for resolution of audits. Marginal improvements in resolution activity should continue in the next few years.

Strategy 02 D: Developing and Retaining a Highly Skilled, Strongly Motivated Financial Management Staff.

In order to accomplish HHS' financial management strategic goals, HHS depends on the competency, productivity, and motivation of its workforce. Given the eligibility of much of the workforce for retirement and the difficulties in attracting accountants and financial systems staff due to the competitive marketplace, HHS is increasing its focus on recruitment, retention, development, and quality of work life for its employees. This objective is supported by human resource and finance initiatives in the OPDIVs and by an overarching effort at the departmental level to forecast future workforce changes and to provide tools for managing those changes.

The first product of this partnership has been developed already. To determine our readiness to meet the current and future financial management challenges, in FY 1999 we issued a financial management survey that was prepared jointly between the Department's Office of Finance and the Office of Human Resources. The Department and the OPDIVs identified where problems exist and shared some best practices.

Performance Area 02 D 1: Training

The Joint Financial Management Improvement Program recently developed the core competencies that are essential for finance staffs to have in order to succeed. In addition, the new financial standards and laws require new technical knowledge. The HHS strategy to address these needs is to develop training plans for financial management staff, to increase the average number of hours of certified training per financial management employee, to use electronic technology as much as possible, and to increase internal HHS training information.

HHS electronic training initiative that was created under the Executive Order 13111 of June 1999 for use by financial management staff. HHS is exploring the use of the Federal Learning Exchange as an approach to supplement HHS internal training and contractor courses. Together with the Office of Human Resources and the OPDIVs, we will encourage and leverage the use of technology to train and educate our staffs under the HHS Distributed Learning initiative.

The Department will continue to provide annual training that addresses the needs identified by the OPDIVs and the core competencies. In addition, the Department obtained the authority to certify the employees that attend training. As a certification sponsor, we will maintain a standard of excellence and will be able to recognize those who take the training.

Performance Area 02 D 2: Recruitment

Given the competition for talented employees, the issue of recruitment of skilled staff is a constant concern of managers in the Department. We will use the booklet entitled Recruiting and Retaining Financial Management Employees as a primary basis for our efforts. In addition, we will continue to participate in CFO Council activities for developing useful recruitment products and strategies. OPDIVs such as PSC, AoA, AHRQ, NIH, and HCFA, are actively using opportunities for successful recruitment, including outreach, intern programs, and participation in CFO Council recruitment pilot with OPM.

Performance Area 02 D 3: Workforce Planning

Based on the survey conducted among the HHS CFOs in FY 1999, there is a need to plan and prepare for a continuing level of expertise after large numbers of the financial staffs retire. Several OPDIVs face an immediate issue and other OPDIVs will shortly face the same issues, given the age and length of service of the workforce. Therefore, it is important to do succession planning and preparation now.

02_D_1_a Increase the availability and quality of financial management training development.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of training hours offered times the number of attendees at ASMB sponsored training sessions	700	2000 (revised)	2000 (revised)	2000 (revised)	2000 (revised)	2400 (revised)	Baseline: FY 1998: 480 estimated (8x60 attendees). More recently, in FY 1999, 2540 hours of training were conducted. The significant increase was a result of stepped up efforts to obtain a clean audit opinion. Also, courses in budget execution were conducted. Targets for future years have been increased to reflect this continuing emphasis and increased use of information technology.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(2) HHS receives and retains official certification as a finance CPE sponsor	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: FY 1998 - No. More recently, in FY 1999, HHS attained certification. Requirements must be met each year in order to retain the certification.
(3) Develop a finance training strategy for the Department in coordination with the OPDIVs	Explore strategies	TBD	TBD	TBD	TBD	TBD	Baseline: FY 1999 Survey was conducted of the training needs of the HHS CFO financial management staff. This was the first step in developing a strategy. The HHS training strategy is reflected in the other training measures of this CFO Five-Year Plan.
(4) Percent of financial employees who have established individual development plans	65% average per 5 OPDIVs	69% average per 6 OPDIVs	80% average per 7 OPDIVs	86% average per 7 OPDIVs	90% average per 7 OPDIVs	94% average per 7 OPDIVs	Supports the CFO Council's Human Resource Committee's proposed performance goal for individual development plans. This measure covers employees in the 501, 510, 525 and 540 series that have training plans. ACF, AHRQ, FDA, NIH, and PSC have established targets for FY 2000, followed by HCFA in FY 2001 and CDC in FY 2002.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(5) Average number of hours of CPE training per financial employee	Develop the baseline.	TBD	TBD	TBD	TBD	TBD	Supports CFO Council's Human Resource Committee's proposed performance goal for maintaining professional certification. It covers employees in the 501, 510, 525, and 540 series. Three OPDIVs have developed targets for this goal, which averages 31 hrs per employee. HHS plans on meeting the CFO Council's proposed goal of 20 hrs, by 2002.

02_D_1_b Increase the effectiveness of HHS-wide training for grants, procurement and logistics.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Results of OPDIV customer surveys conducted biannually by OGAM	3.9 of a 0 to 5 scale	Not applicable	TBD	Not applicable	TBD	Not applicable	Baseline: FY 1998: 3.4 of 5. In FY 1998 the HHS Office of Grants and Acquisition Management developed a survey instrument to measure the effectiveness of its grants, Procurement and logistics functional management. Surveys will be conducted every two years. The next will be in 2000.

02_D_2_a Minimize recruiting time when filling vacancies.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Average numbers of days from OPDIV finance position vacancy to employee start date	86	85 (revised)	85 (revised)	85 (revised)	85 (revised)	85 (revised)	Baseline: FY 1998: 113 average of 4 OPDIVs (CDC, IHS, NIH, and SAMHSA). The measure is based on the date of submission of a vacancy announcement to the Office of Human Resource through to the date the new employee reports for work. There are variables that may affect this calculation. This year the number of OPDIVs participating in the measure has increased from 4 to 8 (HRSA, NIH, CDC, HCFA, AHRQ, AoA, PSC, and SAMHSA), therefore the HHS targets were adjusted to reflect the new average lead-time. The increase in average lead-time was due primarily to the lead-time proposed in one OPDIV; several other OPDIVs targeted as low as 70 days.

02_D_3_a Develop succession planning strategies.

HHS	FY 2000 Target	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	Performance/Comments:
(1) Number of OPDIVs with succession planning strategies for financial management staff	4 PSC, NIH, HRSA, and FDA	5 PSC, NIH, HRSA, FDA, and HCFA	6 OPDIVs (revised) ACF, PSC, NIH, HRSA, FDA and HCFA	6	6	6	Baseline: FY 1999: 2 NIH and HRSA. Basis for measure/targets: Number of OPDIVs that have a documented strategy and evidence of implementation of that strategy. The need for succession planning varies by OPDIVs since the projected turnover rates and potential departures due to retirement, varies by OPDIV. That is why the targets do not currently include all OPDIVs.

APPENDICES

APPENDIX A

HHS Financial Statement Preparation and Audit Five-Year History

Entity	FY 1995		FY 1996		FY 1997		FY 1998		FY 1999	
	Scope of Review/ Audit	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**
HHS	Unaudited	**No**	Full scope	**Disclaim**	Full Scope	**Qualified**	Full Scope	**Qualified**	Full Scope	**Clean**
HCFA	Limited Scope (Balance sheet only)	Disclaim	Full scope	Disclaim	Full Scope	Qualified	Full Scope	Qualified	Full Scope	Clean
ACF	Pre-audit survey	Manage-ment Report	Full scope	Qualified	Full Scope	Qualified	Full Scope	Split	Full Scope	Clean
NIH	N/A	N/A	Internal Control Assessment	Manage-ment Report	Full Scope	Qualified	Full Scope	Split	Full Scope	Clean
HRSA	N/A	N/A	Full scope	Qualified	Full Scope	Qualified	Full Scope	Split	Full Scope	Clean
CDC/ ATSDR	N/A	N/A	Internal Control Assessment	Manage-ment Report	Full Scope	Qualified	Full Scope	Clean	Full Scope	Clean
SAMHSA	N/A	N/A	Full Scope	Qualified	Full Scope	Qualified	Full Scope	Split	Full Scope	Clean
IHS	Limited Scope (Balance Sheet only)	Disclaim	Full Scope	Qualified	Full Scope	Qualified	Full Scope	Split	Full Scope	TBD
FDA	Pre-audit survey	No	Full Scope	Qualified	Full Scope	Qualified	Full Scope	Clean	Full Scope	Clean
PSC	N/A	N/A	SAS 70s	N/A	SAS 70s	N/A	Full Scope	Balance Sheet only	Full Scope	Clean
AoA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
AHRQ	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

N/A = Not Applicable TBD = To Be Determined
Split = Statements of Custodial Activity, Budgetary Resources and/or Financing Disclaimed

APPENDIX B

HHS SUMMARY OF FY 1999 AUDIT FINDINGS BY OPDIV

	HHS	ACF	CDC	FDA	HCFA	HRSA	IHS[1]	NIH	PSC	SAMHSA	[2]
Financial reporting	MW	MW	RC	RC	MW	MW		MW	MW	MW	9
Medicare A/R	MW				MW						2
Medicare EDP	MW				MW						2
Medicare regional office oversight	RC				RC						2
Medicaid error rate	RC				RC						2
EDP	RC	RC	RC (2)	RC		RC		RC (2)	RC	RC	7
Property	RC			RC				RC (2)	RC		3
Medicare payable					RC						1
Fund balance with Treasury		RC				RC		RC	RC (2)	RC	5
Grant accrual		RC									1
Reimbursable agreements			RC			RC		RC		RC	4
Controls over grants			RC (2)					RC			2
Overhead rate			RC					RC			2
Biological products inventory			RC								1
Service & Supply and Management Fund transactions								RC			1
Treasury 2108/SF 133 reporting reqmts								RC			1
Accounts payable and unliquidated obligations								RC			1
Open document file								RC			1
Required authorizations								RC			1
Receipt and acceptance procedures								RC			1
Prompt Payment Act								RC			1
Accurate and timely posting of transactions								RC			1
OPAC processing								RC			1
Payroll								RC			1
Health profession student loan program						RC					1
Accounting for litigation claims						RC					1
Elimination entries									RC		1
Inventory and cost of goods sold									RC		1
Accounts receivable									RC		1
Possible anti-deficiency								CLR			1
FFMIA	CLR	CLR		CLR	CLR	CLR		CLR	CLR	CLR	8
TOTAL	3 MW 4 RC 1 CLR	1 MW 3 RC 1 CLR	8 RC	3 RC 1 CLR	3 MW 3 RC 1 CLR	1 MW 5 RC 1 CLR		1 MW 18 RC 2 CLR	1 MW 7 RC 1 CLR	1 MW 3 RC 1 CLR	

MW = Material Weakness RC = Reportable Condition CLR = Compliance with Laws and Regulations

[1] Audit not complete as of 8/24/00
[2] HHS/OPDIVs affected (NOT # of findings)

APPENDIX C

Department of Health & Human Services
Corrective Action Plan for FY 1999 HHS Financial Statement Audit Findings
Plan and Status as of 6/30/00

Material Weakness	Corrective Actions	Responsible Office	Target Date	Actual Completion Date	Additional Resources Required
1. Financial Systems and Reporting Reconciliations and account analyses were not conducted throughout the year to detect accounting aberrations.	a) HCFA will use trend analysis techniques to identify and track fluctuations and other emerging trends and anomalies in reported results	HCFA CFO	Fall 2000		
	b) HCFA will perform monthly general ledger reconciliations		August 2000		
	c) NIH will implement an improved plan that 'works around' its current system deficiencies to improve the accuracy of financial information.	NIH CFO	September 2000		
	d) Monthly reconciliations will be performed on 9 out of 9 accounts per 7/29/99 HHS policy.	PSC CFO	By the end of the following month	At 7/30, 8 out of 9 accounts + 1 additional quarterly account	
	e) Quarterly reconciliations will be performed on 7 out of 7 accounts per 7/29/99 HHS policy.		By the end of the month following the quarter	At 7/30, 6 reconciled at the end of the 2nd quarter, 1 reconciled monthly, + 3 additional accounts	

APPENDIX C

Material Weakness	Corrective Actions	Responsible Office	Target Date	Actual Completion Date	Additional Resources Required
2. Medicare Accounts Receivable HCFA and the Medicare contractors do not have adequate internal controls to ensure that future receivables will be properly reflected in financial reports.	a) Promote uniform Medicare contractor accounting and reporting by providing additional training to them. b) Identify accounts receivable subcomponents to allow more detailed review and analysis by sending additional instructions to Medicare contractors. c) Validate the accuracy, completeness, and valuation of beginning and interim A/R amounts reported by the Medicare contractors to HCFA, including the adequacy of all supporting documentation. d) Identify systemic problems or weaknesses that require HCFA's issuance of new and/or clarifying Medicare contractor guidance. e) Implement an integrated financial management system at the Medicare contractors.	HCFA CFO	June 2000 October 2000 August 2000 August 2000 FY 2004	June 2000	$1.9 million contract is in place part of contract above

APPENDIX C

Material Weakness	Corrective Actions	Responsible Office	Target Date	Actual Completion Date	Additional Resources Required
3. Medicare EDP Controls over the security, access, ability to change, and continuity of Medicare data need improvement.	a) Implement entity-wide security initiative to administer and oversee HCFA information systems security and train users. b) Implement additional security software to restrict access to Medicare databases. c) Migrate to program change management software. d) Contractors will be given a tool to document their compliance with HCFA's information system security requirements. e) HCFA will conduct an Independent Verification and Validation review of Medicare contractor security program documentation.	HCFA Office of Information Services	Fall 2000 December 2000 December 2000 November 2000 March – June 2001		

APPENDIX D

GOALS AND MEASURES THAT ADDRESS THE AUDIT FINDINGS

Strategic Goal I:

A.1 et al	Financial Statement Audit Opinion Timeliness and clean opinion and resolution of qualifications at HHS and OPDIVs
A.2 et al	Auditor's Report on Internal Controls Resolution of audit material weaknesses and reportable conditions at HHS and OPDIVs
A.3 et al	Report on Compliance with Laws and Regulations Resolution on audit non-compliances at HHS and OPDIVs

Strategic Goal II:

C.4.	Electronic Data Processing Controls Resolution of material weaknesses and reportable conditions at HHS and OPDIVs

APPENDIX E

LIST OF THE HHS GPRA STRATEGIC GOALS AND OMB-CFO COUNCIL MANAGEMENT PRIORITIES THAT THIS PLAN SUPPORTS

The FY 2000 CFO Five -Year Plan supports both the HHS GPRA strategic goals and the OMB-CFO management priorities. The goals and measures of the plan provide the necessary program support that enables HHS programs to achieve the HHS strategic goals. The OMB/CFO management priorities are reflected throughout the CFO Five-Year Plan; all management priorities are addressed.

A. HHS GPRA STRATEGIC GOALS:

GOAL 1. REDUCE THE MAJOR THREATS TO THE HEALTH and PRODUCTIVITY OF ALL AMERICANS.

GOAL 2. IMPROVE THE ECONOMIC and SOCIAL WELL-BEING OF INDIVIDUALS, FAMILIES, and COMMUNITIES IN THE UNITED STATES.

GOAL 3. IMPROVE ACCESS TO HEALTH SERVICES AND ENSURE THE INTEGRITY OF THE NATION'S HEALTH ENTITLEMENT and SAFETY NET PROGRAMS.

GOAL 4. IMPROVE THE QUALITY OF HEALTH CARE and HUMAN SERVICES.

GOAL 5. IMPROVE PUBLIC HEALTH SYSTEMS.

GOAL 6. STRENGTHEN THE NATION'S HEALTH SCIENCES RESEARCH ENTERPRISE and ENHANCE ITS PRODUCTIVITY.

APPENDIX E

B. OMB-CFO MANAGEMENT PRIORITIES:

PRIORITY 1. IMPROVE FINANCIAL ACCOUNTABILITY

PRIORITY 2. IMPROVE FINANCIAL PERFORMANCE

PRIORITY 3. INVEST IN HUMAN CAPITAL

PRIORITY 4. MANAGE OBLIGATIONS TO THE FEDERAL GOVERNMENT

PRIORITY 5. IMPROVE ADMINISTRATION OF FEDERAL GRANT PROGRAMS

APPENDIX F

Department of Health and Human Services
FFMIA Remediation Plan Based on FY 1999 Department-wide Financial Statement Audit Findings
Plan and Status as of June 30, 2000

FFMIA Non-Compliance	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates
1.Financial Reporting	a) Reconciliation will be performed and documented on a monthly or quarterly basis, depending on the nature of the account.	PSC	6/30/01	Partial 10/99 And 6/30/00
	b) PSC will upgrade software to produce Financial Statements	PSC	12/12/00	
	c) PSC is improving the JV posting process, making more time available for analysis of balances.	PSC	09/30/00	
	d) Journal Vouchers prepared for financial statements will be posted to CORE, where appropriate.	PSC	09/30/00	
	e) Correction of budgetary accounts will facilitate available/unavailable appropriation analysis needed for unexpended balances.	PSC	09/30/00	
	f) Current year budgetary accounts are reviewed monthly. Prior year accounts will be tested for accuracy prior to FY-end.	PSC	08/31/00	
	g) Journal Vouchers will be prepared and posted to CORE to correct any exiting errors in budgetary accounts prior to FY-end.	PSC	09/30/00	
	h) The FY 99 closing entries were expanded to include both general ledger and fund symbols not effectively closed in prior years.	PSC	03/31/00	03/31/00
	i) Analyze and enhance the FY99 year-end closing process for full implementation in FY00.	NIH	07/00	
	j) Provide additional training for financial personnel to ensure that they understand the importance of posting entries correctly,	NIH	06/00	06/00

FFMIA Non-Compliance	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates
	performing account analyses and reconciliations, maintaining supporting documentation, and updating their knowledge of financial reporting requirements. k) Update a plan to address immediate accounting needs to improve the accuracy of financial information. Note: Resolving the Financial Reporting weaknesses is a top priority of management. The initial focus was on improving the quality of data in the accounting system. In addition software has been developed to improve the reconciliation and reviews processes for preparing the HHS wide financial statements.	NIH	09/00	
2. Lack of Integrated Financial System for Accounts Receivable and Claims Activity	a) Acquire Systems integrator and JFMIP Commercial off the shelf (COTS). (Planning and Assessment Phase) b) Development/implement an approved JFMIP COTS product. 1) Phase 1 – Medicare Accounts Receivable (A/R - COTS) 2) Phase 2 – Payment Management & CFO Reporting 3) Phase 3 – Replacement of FACS ***An OMB waiver of the three year remediation time is requested due to the multi-year schedule required to implement the integrated system for each of the Medicare contractors.**	HCFA HCFA	03/01 04/02-09/04* 04/02-09/03 09/02-08/03 01/03-09/04*	

FFMIA Non-Compliance	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates
3. Medicare Electronic Data Processing (EDP) Controls				
a) Central Office EDP	The HCFA Security Initiative encompasses all aspects of HCFA information systems security: policy, administration, training, engineering, and oversight. The initiative establishes the structure for an evolving program that establish:			
1) Continue to develop an entity wide security program for all significant production applications and related users.	(a) Technical framework (b) Establish an administrative framework (c) Implementation of security initiative: - Security Plan Methodology - HCFA Security Handbook - Security awareness training		1999 12/00 Ongoing FY 2000 FY 2000 FY 2000	
2) Continue to develop adequate, monitored, and enforceable general computer access controls to restrict sensitive data and other resources from unauthorized usage, modification, or destruction.	(a) Evaluate network and systems access controls and implement procedures restricting unauthorized access. (b) Initiatives to correct M204 deficiencies related to SIRSAFE access control tool include: i) Developed and tested SIRSAFE Capability ii) Transition applications		12/00 09/00 12/00	

FFMIA Non-Compliance	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates
3) Continue to develop entity-wide consistent change control procedures for all significant production applications and systems software programs, which protect against unauthorized changes.	The Endeavor software limits the changes to production application programs to authorized and approved changes. (a) Implementation of Endeavor for the 25 mission critical systems. (b) Naming convention standards approved. (c) Implementation of Endeavor for non-mission critical systems. (d) Project plan to segregate test and production environment drafted.		12/00 12/00 12/00 12/00	
4) Continue to improve segregation of duties to include appropriate assignment of responsibilities.	(a) Infrastructure, applications development, policy, and audit oversight responsibilities will be identified and delineated.		05/00	06/00
5) Inadequate controls over system software integrity and changes properly restricting access to authorized	(a) Evaluate required access to MVS APF libraries and associated system software to reduce the number of individuals with update ability to the minimum necessary. (b) Implement procedures to document system software.		12/00 12/00	

FFMIA Non-Compliance	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates
personnel and protecting against unauthorized changes.				
b) Medicare Contractor EDP Controls				
1) HCFA needs to adhere to OMB A-130 guidelines for entity-wide security plans to ensure appropriate consideration is given to safeguarding Medicare data.	HCFA is revising its information systems security requirements for Medicare contractors. The revision will include HCFA Core Information Security Requirements. The core requirements will be based on a synthesis of OMB A-130, PDD 63, GAO FISCAM, IRS Publication 1075, HIPAA and new HCFA requirements for systems architecture and security handbook. (a) Contractors will be given a tool to document their compliance with the HCFA core requirements. (b) HCFA will conduct an Independent Verification and Validation review of Medicare contractor security program documentation. Contractors will be required to have independent reviews conducted of their implementation of the HCFA core requirements.		12/00 3-6/01	
2) HCFA lacks consistent and effective physical and logical access procedures,	HCFA core information security requirements (see (1) above) include Access control.		09/00	

FFMIA Non-Compliance	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates
including administration and monitoring of access by contractor personnel in the course of their job responsibilities				
3) HCFA lacks consistent and effective procedures over the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data.	HCFA core information security requirements (see (1) above).		09/00	
4) Lack of segregation of duties to ensure accountability and responsibility for access to Medicare applications and	HCFA core information security requirements (see (1) above) include configuration management.		09/00	

FFMIA Non-Compliance	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates
data.				
5) HCFA needs to update and appropriately document service continuity procedures to recover Medicare processing in the event of a system outage.	HCFA core information security requirements (see (1) above) include configuration management.		09/00	

APPENDIX G

ACRONYM LIST

Accounting Branch	AB
Administrative Data Base	ABD
Administration for Children and Families	ACF
Administration on Aging	AoA
Agency for Healthcare Research and Quality	AHRQ
Agency for Toxic Substances and Diseases Registry	ATSDR
Assistant Secretary for Management and Budget (OS)	ASMB
British Thermal Unit	BTU
Construction in Progress	CIP
Center for Information Technology	CIT
Centers for Disease Control and Prevention	CDC
Chief Financial Officer	CFO
Departmental Accounting Manual	DAM
Debt Collection Improvement Act	DCIA
Delegated Procurement System	DELPRO
Electronic Data Interchange	EDI
Electronic Data Processing	EDP
Electronic Funds Transfer	EFT
Federal Agencies Centralized Trial Balance System	FACTS
Financial Assistance Reporting System	FARS
Federal Accounting Standards Advisory Board	FASAB
Food and Drug Administration	FDA
Federal Financial Assistance Management Improvement Act	FFAMIA
Federal Financial Management Improvement Act	FFMIA
Federal Financial System	FFS

APPENDIX G

Financial Management	FM
Federal Managers Financial Integrity Act	FMFIA
Financial Management Officers	FMO
Financial Policies Group	FPG
Federal Travel Regulation	FTR
Fiscal Year	FY
General Services Administration	GSA
Government Paperwork Elimination Act	GPEA
Government Performance and Results Act	GPRA
Health Care Financing Administration	HCFA
Department of Health & Human Services	HHS
Human Resources Management	HRM
Health Resources and Services Administration	HRSA
Institutes and Centers	IC
Indian Health Service	IHS
Information Technology	IT
International Merchant Purchase Authorization Card	I.M.P.A.C.
Investment Review Board	IRB
Internal Revenue Service	IRS
Joint Financial Management Improvement Program	JFMIP
National Institutes of Health	NIH
Not Applicable	N/A
Office of Finance (OS)	OF
Office of Government Ethics	OGE
Office of Grants and Acquisition Management (OS)	OGAM
Office of Inspector General	OIG
Office of Management and Budget	OMB

APPENDIX G

On-line Payment and Collection	OPAC
HHS Operating Divisions	OPDIV
Office of the Secretary	OS
Paperwork Reduction Act	PRA
Payment Management System	PMS
Program Support Center	PSC
Property, Plant, and Equipment	PP&E
Resource Access Control Facility	RACF
Standard General Ledger	SGL
Standard General Ledger Documentation Database System	SGLDDS
Substance Abuse and Mental Health Services Administration	SAMHSA
HHS Staff Divisions	STAFFDIV
Time and Attendance	TA
To Be Determined	TBD
Tracking Accountability in Government Grants System	TAGGS
Treasury Financial Manual	TFM
United States	US
Year 2000 Compliant	Y2

APPENDIX H

LEGISLATIVE REFERENCES

FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT OF 1982

The Federal Managers' Financial Integrity Act (FMFIA) of 1982, Public Law 97-255, was signed into law September 8, 1982 to amend the Accounting and Auditing Act of 1950. It requires ongoing evaluations and reports on the adequacy of the systems of internal accounting and administrative control of each executive agency.

CHIEF FINANCIAL OFFICERS ACT OF 1990

The Chief Financial Officers (CFO) Act of 1990 focused attention on financial management improvements in the Federal Government by requiring the identification of a responsible official to adverse financial management. The law created a framework for financial organizations to focus on the integration of accounting, budget and other financial activities under one umbrella; the preparation of audited financial statements; and the integration of financial management systems. It also requires federal agencies to prepare a CFO strategic five-year plan. The Act required 14 Cabinet level Departments and ten major agencies to establish the position of a CFO who reports to the agency head.

GOVERNMENT PERFORMANCE AND RESULTS ACT OF 1993

The Government Performance and Results Act (GPRA) which is to be fully implemented beginning in FY 1999, has placed new management expectations and requirements on federal agencies by creating a framework for more effective planning, budgeting, program evaluation and fiscal accountability for Federal programs. The intent of the Act is to improve public confidence in Federal agency performance by holding agencies accountable for achieving program results and to improve Congressional decision making by clarifying and stating program performance goals, measures and costs up front. Federal agencies are required to implement GPRA through their processes for strategic plans, annual performance plans, and annual performance reports. FY 1999 is the first year that annual performance plans are required. Actual accomplishments for FY 1999 are required to be reported in FY 2000.

APPENDIX H

GOVERNMENT MANAGEMENT REFORM ACT OF 1994

The Government Management Reform Act (GMRA) amends the CFO Act and expands requirement for audited financial statements to cover all programs. It also provides OMB with the authority to streamline statutory reporting by Federal agencies, requires the use of electronic funds transfer for payments to Federal employees and beneficiaries, and creates the Franchise Fund Pilot program for studying the concept of government enterprise.

FEDERAL ACQUISITION STREAMLINING ACT OF 1994

The Federal Acquisition Streamlining Act (FASA) of 1994 was enacted to revise and streamline the acquisition laws of the Federal government. FASA also expanded the definition of records, placed additional record retention requirements, and gave agencies statutory authority to access computer records of contractors doing business with the government.

PAPERWORK REDUCTION ACT OF 1995

The Paperwork Reduction Act of 1995 (PRA) requires that HHS minimize paperwork burden on the public and ensure the greatest public benefit from the use of information. The PRA specifies more explicit agency responsibilities for information collection and certification, for public comment, and for meeting yearly goals. In addition, it defines and ezpands certain terms that determine the scope of agency responsibilities.

APPENDIX H

DEBT COLLECTION IMPROVEMENT ACT OF 1996

The Debt Collection Improvement Act (DCIA) of 1996, Public Law 104-134, was signed into law April 26, 1996. The law's provisions will enhance and improve debt collection government-wide

Key provisions of the Act are:

- Enhanced administrative offset authority, the Treasury Offset Program
- Enhanced salary offset authority
- Taxpayer Identification Numbers are required
- General extension of the Debt Collection Act of 1982 authorities
- Barring delinquent debtors from obtaining Federal credit
- Reporting to credit bureaus
- Government-wide cross servicing
- Establishment of debt collection centers
- Gainsharing
- Tax refund offset program
- Contracting with private attorneys
- Administrative wage garnishment
- Debt sales by agencies.

FEDERAL FINANCIAL MANAGEMENT IMPROVEMENT ACT OF 1996

The Federal Financial Management Improvement Act (FFMIA) of 1996, Public Law 104-208, requires that each agency shall implement and maintain financial management systems that comply substantially with Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level.

APPENDIX H

INFORMATION TECHNOLOGY MANAGEMENT REFORM ACT OF 1996

Information Technology Management Reform Act (ITMRA) ensures that the Federal Government investment in information technology is made and used wisely. The law was designed to increase competition, eliminate burdensome regulations, and help the Government benefit from efficient private sector techniques.

ITMRA requires agencies to develop a formal process for maximizing the benefits of information technology acquisition, including planning, assessment, and risk management.

The Act created the statutory position of Chief Information Officer in major Federal Government agencies. It requires the Office of Management and Budget, the agencies, and the Chief Information Officers to improve information technology practices. It requires mission and program driven strategic planning for information technology. It requires senior user management guidance to ensure information technology activities align with agency plans and operations. It requires regular assessments of information technology skills inventory, skills requirements, and skills development programs. In short, the ITMRA requires the development of an effective and efficient, mission-oriented, user-oriented, results-oriented information technology practice in each and every Federal agency.

GOVERNMENT PAPERWORK ELIMINATION ACT OF 1998

The act requires that Executive branch agencies provide within five years for the option of the electronic maintenance, submission, or disclosure of information when practicable as a substitute for paper, and for the use and acceptance of electronic signatures, when practicable

APPENDIX H

TRAVEL AND TRANSPORTATION REFORM ACT OF 1998

The Travel and Transportation Reform Act of 1998 (TTRA): required Federal employees to use Federal travel charge cards for all payment of official Government travel; amended title 31, United States Code, to establish requirements for prepayment audits of Federal agency transportation expenses; authorized reimbursement of Federal agency employees for taxes incurred on travel or transportation reimbursements; and authorized test programs for the payment of Federal employee travel expenses and relocation expenses.

FEDERAL ACTIVITIES INVENTORY REFORM ACT OF 1998 (FAIRA)

On October 19, 1998, the Federal Activities Inventory Reform Act of 1998 (FAIRA) was signed into law. This landmark legislation requires federal agencies to list activities eligible for privatization and to make this list available to the public. FAIRA permits prospective contractors and other interested parties to challenge the omission of particular activities from the list. Nevertheless, although agencies are directed to review the list, FAIRA does not actually require agencies to privatize listed activities. However, the legislation directs agencies to review the activities on the list soon after the list has been made available to the public.

FEDERAL FINANCIAL ASSISTANCE MANAGEMENT IMPROVEMENT ACT of 1999 (FFAMIA)

This law requires OMB to direct, coordinate, and assist the agencies in a process to: (1) streamline application and reporting forms used in the administration of grants; (2) provide uniform administrative requirements for use in all federal grant programs; and (3) provide an electronic option for the administration of grants.

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