Department of Health and Human Services

FY 2004 Financial Management Five Year Plan

Issuance Date: October 1, 2004

INTRODUCTION

This FY 2004 HHS Financial Management Five Year Plan continues the tradition of evolving to reflect current strategies in Federal financial management and financial management within HHS, in particular. We continue to prepare this document for a largely internal Federal audience to communicate the HHS' financial management priorities to our financial managers. We also continue to present our strategies, goals and targets in a format supportive of the Government Performance and Results Act (GPRA), similar to the approach taken by HHS program areas.

The Office of the Assistant Secretary for Budget Technology and Finance (ASBTF) has three primary financial management objectives: retaining a "clean" opinion on the Department's financial statements while accelerating the reporting date to November 15, implementing the Unified Financial Management System (UFMS), and reducing improper payments.

These three priorities, as well as our numerous performance measures, embody the Deputy CFO's two strategic goals that were identified in 1998:

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

This Plan is prepared as referenced in the Federal Register Notice, Vol. 68 Number 47, (page 11555)-March 11, 2003.

IMPROVING FINANCIAL PERFORMANCE

HHS is committed to meeting the President's Management Agenda (PMA) and is working to achieve "green" OMB status and progress ratings on the PMA Scorecard for Improving Financial Management. HHS provides information to OMB quarterly that reflects our progress on improving the status of elements of the scorecard.

Strong financial management provides a solid and necessary foundation for effective program performance, and improving HHS' financial management and related infrastructure is one of Secretary Thompson's highest priorities. The Department's efforts to improve financial management are focused in areas which are the main focus points of the PMA Financial Management Element: 1) maintaining clean opinions on the HHS annual financial statements while accelerating the reporting timeframe, 2) implementing an integrated financial management system across the Department, and 3) identifying and reducing improper payments.

Accelerating Financial Reporting and Maintaining Clean Opinions

HHS has achieved "clean" opinions on its Department-wide audited financial statements annually since FY 1999, regardless of the fact that the Department currently lacks a fully integrated financial management system.

In FY 2003, HHS published its Department-wide financial statements in the Performance and Accountability Report on November 15, a full 75 days before the OMB deadline of January 31. This accelerated schedule was part of a pilot program so that in FY 2004 the Department would be able to meet the new FY 2004 OMB deadline of November 15. To accomplish this goal, HHS changed its audit approach form "Bottom Up" to "Top Down." This approach reduces the number of OPDIV-entity full scope audits without sacrificing the financial integrity of the Department-level statements. It calls for specialized audit work on various accounts that are material to the Department-level financial statements which will be tested on a random basis, and enable HHS to meet the November 15 target reporting date.

In addition to the accelerated audit timeline, there are two new reporting challenges for FY 2004 and beyond. First, beginning in the second fiscal quarter of this year, the timeline for submitting quarterly, Department-level financial statements to OMB has been accelerated to 21 days. Second, FMS is requiring all government departments, including HHS, to submit their financial statements to Treasury according to the requirements outlined in their closing package. Since the closing package guidelines are different from the reporting requirements outlined by the OIG and our auditors, HHS will have to reconfigure its financial systems in order to produce a second set of financial statements specifically for FMS.

Beyond re-engineering departmental reporting and auditing processes to accommodate the accelerated quarterly reporting and the closing package requirements, HHS is also working to resolve audit findings (material weaknesses and reportable conditions) at both the Department and the component agency levels.

HHS has been submitting quarterly Corrective Action Plans (CAPs) to OMB since March 1992. These CAPs address findings from the Department's financial statement audits and the FMFIA and FFMIA reports in an integrated manner to reduce redundant reporting and tracking procedures. Quarterly progress is detailed in order to support OMB's quarterly scorecard rating for HHS on financial management. It is important to note that the annual audits of each OPDIV will no longer be available (except as explained in Appendix C) to determine the existence or resolution of OPDIV-level material weaknesses and reportable conditions. However, HHS will continue to report on all previous findings in the quarterly CAPs until management and/or the auditors believes they have been resolved.

The HHS Office of Finance has begun developing a quality assurance strategy which will measure the effectiveness of corrective actions cited in the Corrective Action Plan (CAP) that are being implemented to resolve audit findings.

Developing and Implementing a Unified Financial Management System

Over the last few years, HHS financial auditors have cited the Department's lack of an integrated accounting system as a material weakness and a specific impediment in preparing timely financial reports and statements. Secretary Thompson has directed a "One HHS" approach to managing the Department. One of the major tenets of the Secretary's approach is the development and implementation of a Unified Financial Management System (UFMS) for the Department. In accordance with Secretary Thompson's June 2001 direction, the UFMS is to be composed of two primary components—one component, HIGLAS, for the Centers for Medicare & Medicaid (CMS) and another component, UFMS, for the rest of the Department. Once completed, UFMS will be the largest civilian financial management system in the federal government. Together, these two components will be integrated to provide for Department-wide financial reporting. The unified system is to generate interim and annual financial statements, as well as other required external and internal financial reports. Effective design and implementation of the UFMS should resolve the Office of the Inspector General audit finding regarding current financial system weaknesses. We believe that in FY 2005, UFMS will be substantially implemented and that the material weakness for financial systems and reporting will be eliminated. However, until the system is fully operational across the Department in FY 2007, HHS will continue to confront significant challenges in meeting accelerated financial reporting dates established by OMB.

HHS management has defined a number of strategic objectives related to the UFMS initiative:

- Eliminate redundant and outdated financial systems by implementing a modern integrated HHS-wide system.

- Produce reliable, timely and relevant financial information to help HHS managers make fact-based decisions to improve service to customers.
- Comply with federal financial management system requirements, as well as accounting standards and financial reporting requirements.
- Strengthen internal controls by instituting business rules, data standards and accounting policies across HHS.
- Continue to achieve unqualified audit opinions on annual financial statements.

HHS also identified the following Critical Success Factors for the UFMS:

- Sustaining commitment from HHS top leadership;
- Developing and articulating a clearly-defined scope;
- Obtaining dedicated staffing resources (Departmental and contractor) with the knowledge, skills and abilities to successfully accomplish program objectives;
- Defining and meeting HHS business requirements;
- Securing adequate funding to sustain the project;
- Coordinating with other Department-wide initiatives;
- Creating a unified team comprised of highly qualified representatives from HHS component agencies;
- Developing and executing a comprehensive implementation plan, to include:
    - Acquisition Planning,
    - Change/Communication Management,
    - Financial Management,
    - Performance Management,
    - Quality Control, and
    - Risk Management.

Making Progress in Estimating Improper Payment Rates/Amounts

HHS has been a leader in the area of monitoring and mitigating improper payments. HHS began measuring errors in Medicare in 1996 and has made progressive strides in reducing errors. The FY 2003 adjusted rate of 5.8 percent is less than half the 13.8 percent estimated in fiscal year 1996. Building upon Medicare's success in measuring errors, the Department is well into the process of creating a payment accuracy measure in the Medicaid and SCHIP Programs. Notice for proposed rule making requiring that States implement the Medicaid Payment Error Rate Measurement (PERM) (formerly the Payment Accuracy Measurement and revised to

include SCHIP) program was published in the Federal Register in FY 2004. Further, work was done in the Head Start, Foster Care, TANF, Child Care, and Foster Care Programs to identify/reduce improper payments in these programs.

The Improper Payment Information Act of 2002 (IPIA) requires agencies to annually review all programs to identify programs susceptible to more than $10 million in erroneous payments. Related OMB Guidance requires that agencies conduct risk assessments and report on programs that have estimated annual erroneous payments exceeding both 2.5% of program payments and $10 million. HHS completed program risk assessments for FY 2004. and the FY 2005 program risk assessments will be improved upon based on the FY 2004 work.

Section 831 of the Defense Authorization Act for FY 2002 requires that agencies institute a recovery audit program to identify and recover amounts erroneously paid to contractors. HHS recently made an award to a contractor for recovery auditing services. During FY 2005, it is expected that each of the five HHS contract payment offices will have worked with the recovery auditing contractor and determined amounts of improper payments related to FY 2003 contract payment actions.

Both the IPIA requirement and recovery auditing mandate are related to the PMA initiative to reduce improper payments in Federal programs that, up until FY 2004, was included under the improved financial management initiative. Beginning in FY 2005, the improper payment initiatives will be under a stand-alone program initiative; "Eliminating Improper Payments Initiative." This serves to highlight the importance of the PMA initiative to reduce improper payments in Federal Programs.

Ensuring Quality Awardee Audit and Oversight

HHS works closely with its partners including states, local governments, and tribes, to ensure they understand Federal regulation, requirement, policy, etc. Since all are accountable to taxpayers for use of the federal funds, audits of the use of those funds are conducted at the partner level as well as the HHS level. In addition to the other grants management improvements discussed above, HHS has committed to timely audit resolution in the HHS ASBTF GPRA plan. Also, HHS provides assurance of the quality of audits performed by non-federal auditors via a multi-tiered approach as follows:

- Quality Control Reviews performed by the Office of Inspector General's (OIG) National External Audit Review (NEAR) Center, discussed below,
- Maintenance of an up-to-date HHS Audit Compliance Supplement providing complete coverage of major programs and guidance to the auditor,
- Referral of non-federal auditors to the NEAR center and/or state societies for disciplinary review as a result of findings during the normal audit resolution process, and

- Technical assistance provided at various association meetings, state societies, internet-posted questions and answers, and individual discussion.

The OIG's NEAR center performs desk reviews on all single audit reports received from the Census Bureau. The findings and recommendations are summarized and identified by federal department officials responsible for the resolution. A written response to the HHS resolution official is requested within 30 days from the date the letter was sent out by NEAR. In addition, quality control reviews (QCR's) of states, local governments, and non-profit organizations audits under OMB Circular A-133, are performed during the year.

Shared Services

The Financial Shared Service Center (FSSC) concept represents an opportunity of HHS to reorganize and reenergize key financial management activities to provide effective, efficient, and economical business services. Simply stated, HHS can optimize the use and productivity of new standardized financial processes, a new financial ERP system termed the Unified Financial Management System (UFMS), and its workforce by combining and co-locating certain financial management processes into a FSSC for the future. By consolidating certain financial management activities for the department, HHS has the opportunity to achieve greater economies of scale and also provide a consistent, high quality, "one-face" service to internal operating divisions, headquarters, employees, and to external customers and stakeholders.

A work group created to study this issue has identified four functions as strong candidates to begin shared services. These functions are operations, and maintenance for UFMS, customer service, vendor payments, and e-travel. Based on the recommendations and concerns to date HHS will need to take the following steps towards transitioning to shared services:

- Establish project management
- Baseline current operations
- Establish the FSSC within the current Board of Governors
- Obtain approval to fund the FSSC through the Service Supply Fund
- Establish communication plan and begin communications
- Develop business controls
- Document the FSSC Provider Selection Process
- Define metrics and develop continuous improvement plan

Shared services will address the internal control weakness citied by the independent auditors and the OIG office as well as create, through the consolidation of often-disparate activities, more of a "one company" feel among business units which directly supports Secretary Thompson objective creating "One HHS."

Using Financial and Performance Information for "Day-to-Day" Decision Making

In order to more effectively manage Department programs, operations, and resources HHS program managers and division directors should have access to and use key financial and performance data at critical points throughout the year. This information should ultimately be available and used to support routine or 'day to day' program and management decisions, and should address those issues most critical to managers. Access to and use of financial information on a 'day to day' basis is one of criteria agencies must meet to earn a 'green' rating in the *Improved Financial Performance* element of the President's Management Agenda (PMA),

Recent emphasis has been on producing financial information in a more timely manner (e.g., meeting the accelerated November 15 submission date for the Performance and Accountability Report (PAR). Once an accelerated process is in place, facilitated by the full implementation of UFMS, it is critical that agencies shift efforts and emphasis from producing to using this information.

HHS is a broad, widely diverse Department, comprised of largely autonomous OPDIVs that administer hundreds of programs. HHS has contracted with an independent accounting and consulting firm to assess the extent to which OPDIVs are currently producing and using financial information to support 'day to day' program decisions and to identify where improvement opportunities exist. The firm conducted a preliminary study during FY 2004 to identify commendable practices and areas to target further research. During FY 2005, HHS will issue a contract to conduct a more in-depth study of the recommended areas as well as conduct a benchmarking study to determine the steps HHS must take to meet the OMB criteria for 'day to day' management.

Measure	FY 2004 Target	FY 2005 Target	FY 2006 Target	FY 2007 Target	FY 2008 Target	FY 2009 Target	Performance/Comments
HHS Performance and Accountability Report and audited financial statements for CMS are submitted to OMB by Nov. 15	Yes - Pilot	Yes	Yes	Yes	Yes	Yes	Baseline: No for the FY 1996 audited financial statements. More recently, the FY 2002 HHS and CMS statements were submitted timely on 1/29, two days ahead of the OMB deadline of 1/31.
Number of department-level material weaknesses	1	1	1	0	0	0	Baseline: FY 1997 - 5 material weaknesses were cited in the HHS audit opinion. More recently, in FY 2003, the audit opinion cited 2 material weaknesses: financial systems/processes and Medicare contractor EDP controls. The material weakness for Medicare EDP controls is expected to be resolved in FY 2004. The material weakness for financial systems and processes will be substantially resolved in 2005 with the partial implementation of the Unified Financial Management System (UFMS), along with HIGLAS being implemented at 10 contractors equating to 75% of outstanding Medicare receivables.
Number of department-level reportable conditions	1 (Info. Sys. Controls)	0	0	0	0	0	Baseline: FY 1997 - 3 reportable conditions. More recently, in FY 2003, there was 1 reportable condition Departmental Information Systems Controls. We believe this issue will be substantially resolved with the partial implementation of UFMS in 2005.

Measure	FY 2004 Target	FY 2005 Target	FY 2006 Target	FY 2007 Target	FY 2008 Target	FY 2009 Target	Performance/Comments
OMB's PMA assessment rating for financial management progress	Green	Green	Green	Green	Green	Green	New Performance Measure for the Five Year Plan. (Quarterly ratings)
OMB's PMA assessment rating for financial management status	Yellow	Yellow	Yellow	Green	Green	Green	New Performance Measure for the Five Year Plan. (Annual rating)
Number of department-level instances of FFMIA non-compliance	1	0	0	0	0	0	Baseline: FY 1997 – 4 instances of non-compliance. More recently, in FY 2003, HHS had 2 non-compliances with the Federal Financial Management Improvement Act. These two items are duplicates of the financial statement audit material weaknesses: financial systems and processes and Medicare EDP controls. The material weakness for Medicare EDP controls is expected to be resolved in FY 2004. Plans call for achieving substantial compliance on financial systems and processes in 2005. Note: Assumes 75% of Medicare receivables are in HIGLAS in 2005. (See quarterly Corrective Action Plan.)
Percentage of Medicare contractors that will be subjected to a SAS 70	33%	33%	33%	33%	33%	33%	Baseline: FY 2000 - 26 of 50 contractors had SAS-70 reviews; 19 of the contractor's SAS 70 reviews covered Part A; 16 covered Part B. 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, CMS will continue SAS 70s of Medicare contractors using a more detailed approach (Type II). CMS plans to review all Medicare contractors remaining in the program at least once in a three-year period.

Measure	FY 2004 Target	FY 2005 Target	FY 2006 Target	FY 2007 Target	FY 2008 Target	FY 2009 Target	Performance/Comments
Number of OIG/NEAR Quality Control Reviews-OIG Lead Agency	6	TBD	TBD	TBD	TBD	TBD	In FY 1999 and FY 2000, 14 reviews were completed. On FY 2002, 7 reviews were completed.
Number of OIG/NEAR Quality Control Reviews-OIG Supporting Agency	6	TBD	TBD	TBD	TBD	TBD	In FY 1999, 3 reviews were completed, and 1 was completed in FY 2000. In FY 2002, 7 reviews were completed.
Number of Quality Control Reviews-Contractor Personnel	0	TBD	TBD	TBD	TBD	TBD	In FY 1999, 7 reviews were completed, and 0 were completed in FY 2000. In FY 2002, 3 reviews were completed.
Percentage increase of collections over prior year	10% increase	10% increase	10% increase	10% increase	10% increase	10% increase	Baseline: FY 1998: $13.3 billion. More recently, in FY 2003, $16.1 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 $1.7 billion increase in dollars collected over FY 2002 is 11.8%. This exceeds the 10% target.
Percentage of eligible 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 2003, 94.7% of eligible debt was referred to Treasury for cross-servicing. Targets of 100% are in accordance with law (DCIA of 1996). CMS is a key HHS component in achieving these targets.

Measure	FY 2004 Target	FY 2005 Target	FY 2006 Target	FY 2007 Target	FY 2008 Target	FY 2009 Target	Performance/Comments
Percentage 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 2003, 93.2% was referred to Treasury. Targets of 100% are in accordance with law (DCIA of 1996). CMS is a key HHS component in meeting these targets.
Number of Department level FMFIA material weaknesses/non-conformances pending at year end							Baseline: FY 1997: 7 FY 2003: 2.
Section 2	0	0	0	0	0	0	FDA identified 2005 as the target date for resolving the food safety material weakness.
Section 4	1 (Fin. Sys & Processes/EDP Controls)	1 (Fin. Sys & Processes/EDP Controls)	0	0	0	0	Financial systems and processes is expected to be substantially resolved in 2005, assuming 75% of Medicare contractors accounts receivable are on HIGLAS. The Medicare EDP controls citing is expected to be resolved in FY 2005.
Percentage of vendor payments made on time	97%	97.5%	97.5%	97.5%	97.5%	97.5%	Baseline: FY 1998: 91%. More recently, in FY 2003, 97.4% was achieved. Because of the volume of their activities, NIH, IHS, and PSC are the HHS components that have a critical impact on meeting these targets.

Appendix A: HHS AND HHS OPDIV AUDIT OPINION HISTORY

Entity	1996	1997	1998	1999	2000	2001	2002	2003
HHS	Disclaim	Qualified	Qualified	Clean	Clean	Clean	Clean	Clean
CMS	Disclaim	Qualified	Qualified	Clean	Clean	Clean	Clean	Clean
ACF	Qualified	Qualified	Split	Clean	Clean	Clean	Clean	Clean
AHRQ	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clean
AoA	N/A	N/A	N/A	N/A	N/A	Clean	N/A	Clean
CDC	Mgt Rpt-I/C Assess	Qualified	Clean	Clean	Clean	Clean	Clean	Clean
FDA	Qualified	Qualified	Clean	Clean	Clean	Clean	Clean	Clean
HRSA	Qualified	Qualified	Split	Clean	Clean	Clean	Clean	Clean
IHS	Qualified	Qualified	Split	Qualified	Qualified	Clean	TBD	Clean
NIH SSF	Mgt Rpt-I/C Assess	Qualified	Split	Clean	Clean	Clean	Clean	Clean
OS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Clean
PSC	N/A	N/A	N/A	Clean	Clean	Clean	Clean	Clean
SAMHSA	Qualified	Qualified	Split	Clean	Clean	Clean	Clean	Clean

Note: The OPDIVs receiving a shaded "Clean" opinion for FY 2003 represent a change in auditing procedures by the Department going forward. With the HHS audit being conducted in a "Top-Down" manner, the OIG will no longer opine on individual OPDIVs with the exception of CMS. A Departmental "Clean" opinion reflects that the component agencies are "Clean" as well.

Split: Statements of Custodial Activity, Budgetary Resources and/or Financing Disclaimed

N/A: Not Applicable

Appendix B: SUMMARY OF FY 2003 AUDIT FINDINGS BY HHS COMPONENT

			TOP DOWN OPDIVS**										
Area	**HHS**	**CMS**	**ACF**	**AoA**	**AHRQ**	**HRSA**	**IHS**	**SAMHSA**	**CDC**	**NIH SSF**	**FDA**	**PSC**	**Total**
Financial systems and processes	1 MW	1 MW											2
Medicare Information Systems Controls	1 MW	1 MW											2
Medicare regional office oversight													
Medicaid error rate													
Information Systems Controls	1 RC												1
Property													
Fund balance with Treasury													
Grant financial management													
Reimbursable agreements													
Controls over grants													
Accounts payable and unliquidated obligations													
HEAL Allowance for Uncollectible Accounts													
Accounting for litigation claims													
Accounts receivable													
FFMIA													
TOTAL	2 MW 1 RC	2 MW											5

TBD=To Be Determined MW = Material Weakness CLR = Compliance with Laws and Regulations citing RC = Reportable Condition

****Changes since 2002 audit results:**

In an effort to meet the accelerated reporting requirement of November 15, the Department conducted a pilot. To support this effort, the Department implemented the Top Down audit approach. There are 10 Operating Divisions (OPDIVs) under the Top Down, which means that the OPDIVs are considered 'one' entity for auditing purposes.

Appendix C: HHS RECEIVABLES MANAGEMENT PERFORMANCE TRENDS

(Dollars in billions)

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Beginning Receivables	$10.3	$9.8	$10.2	$10.8	$10.1
New Receivables	$18.6	$18.7	$17.0	$16.6	$17.2
Accruals	$0.5	$0.7	$0.7	$0.5	$0.4
Total Receivables	**$29.4**	**$29.2**	**27.9**	**$27.9**	**$27.7**
Less:					
Collections	$14.3	$15.3	$14.4	$14.4	$16.1
Adjustments	$2.3	$3.1	$2.1	$2.4	$1.7
Write-offs	$3.0	$0.6	$0.6	$1.0	$1.3
Ending Receivables	**$9.8**	**$10.2**	**$10.8**	**$10.1**	**$8.6**
Collections as a % of:					
Total Receivables	48.6%	52.4%	51.6%	51.6%	58.1%
Beginning & New	49.5%	53.7%	52.9%	52.6%	59.0%
Collections + Adjustments + Write-Offs as a % of:					
Total Receivables	66.7%	65.1%	61.3%	63.8%	69.0%
Beginning & New	67.8%	66.7%	62.9%	65.0%	70.0%
Write-Offs as a % of:					
Total Receivables	10.2%	2.1%	2.2%	3.6%	4.7%
Beginning & New	10.4%	2.1%	2.2%	3.7%	4.8%
Collections	15.3%	3.2%	3.5%	5.6%	8.1%
Delinquencies:					
1 to 90 Days	$1.0	$0.7	$0.5	$0.4	$0.2
91 to 180 Days	$0.5	$0.5	$0.2	$0.2	$0.1
181 Days to Over 10 Years	$3.3	$4.9	$5.0	$4.6	$3.9
Total Delinquent	$4.8	$6.1	$5.7	$5.2	$4.2
Delinquencies as a % of Total Receivables:					
1 to 90 Days	3.4%	2.4%	1.8%	1.4%	0.7%
91 to 180 Days	1.7%	1.7%	0.7%	0.7%	0.4%
181 Days to Over 10 Years	11.2%	16.8%	17.9%	16.5%	14.1%
Total Delinquent	16.3%	20.9%	20.4%	18.6%	15.2%