Management Discussion and Analysis

(This page intentionally left blank)

Management Discussion and Analysis

Introduction

The Department of Health and Human Services (HHS) is the principal Federal agency responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Encompassing hundreds of programs, HHS is the Nation's largest health insurer and the U.S. Government's largest grant-making agency.

The HHS FY 2004 *Performance and Accountability Report* (*PAR*) is produced under the Reports Consolidation Act of 2000 and covers fiscal year (FY) 2004 (October 1, 2003, through September 30, 2004). The *PAR* contains a high level overview of:

- The Department's purposes, programs, accomplishments, and challenges;
- The nature of resources entrusted to HHS; and
- HHS' management of and accountability for those resources.

This is HHS' third *PAR*, and ninth annual report prepared pursuant to the Chief Financial Officers' Act, as amended. In this report to the Department's "stockholders," the American public, HHS accounts for the return on the taxpayers' investment. HHS also provides this information to a wide array of decision makers, including the Office of Management and Budget (OMB) and the Congress.

The report contains a discussion of key program, management, financial, and performance information (Sections I and II); HHS' FY 2004 financial statements that discuss the Department's financial condition (Section III); and the auditors' opinion (Section IV), which is an independent, objective assessment that provides reasonable assurance about whether the financial statements are free from material misstatements. Finally, this comprehensive report contains other streamlined statutorily required information that demonstrates management accountability, and financial and program performance (Section V).

This report is designed to provide a complete, accurate, and useful understanding of HHS. HHS' component Agencies also issue Agency-specific reports, which provide more detailed program and financial information. These and other reports can be found at the individual Agency's respective websites (see *HHS Agency Description and Highlights* later in this document). An electronic version of this report may be found on the HHS website at www.hhs.gov/of/reports.

Mission and Strategic Goals

Healthy and productive individuals, families, and communities are the very foundation of the Nation's security and prosperity. Under HHS' programs, initiatives, and leadership, virtually all Americans and many others throughout the world are positively impacted by the Department's direct health services, advances in science, and dissemination of information to help improve healthy decision making. In a society that is diverse in

HHS' Mission

"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."

culture, language, and ethnicity, HHS also manages an array of programs that aim to improve health status and access to health services and increase opportunities for disadvantaged individuals to work and lead productive lives.

Secretary Tommy Thompson has identified several high priority goals needing urgent attention, including preparedness for terrorism incidents, emphasis on healthy choices and disease prevention practices for Americans, and continued progress in helping all Americans become self-sufficient. HHS also focuses on measuring and reducing improper payments, encouraging senior citizens to take advantage of the new prescription drug benefit under Medicare, and reducing burdensome HHS regulations. To carry out its mission, HHS articulated these priorities in its FY 2004 - FY 2009 *Strategic Plan* through eight strategic goals and hundreds of performance measures. The Department's performance report (Section II) and the performance overview later in this section tie the representative performance measures to the strategic goals. HHS also has aligned its efforts with the President's Management Agenda (PMA) initiatives, which articulate the Administration's strategy for "improving the management and performance of government."

HHS Strategic Goals

1. Reduce the Major Threats to the Health and Well-being of Americans.
2. Enhance the Ability of the Nation's Health Care System to Effectively Respond to Bioterrorism and Other Public Health Challenges.
3. Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care Services, and Expand Consumer Choices.
4. Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise.
5. Improve the Quality of Health Care Services.
6. Improve the Economic and Social Well-being of Individuals, Families, and Communities, Especially Those Most in Need.
7. Improve Stability and Healthy Development of Our Nation's Children and Youth.
8. Achieve Excellence in Management Practices.

Scope of Services

HHS accomplishes its eight strategic goals by managing and delivering hundreds of programs across several disciplines. The following illustrates the breadth of activities that occur at HHS and indicates the strategic goals that they support.

- Conduct and sponsor medical and social science research to improve Americans' health and well-being (Goal 4);
- Guard against the outbreak of infectious diseases through immunization services and the elimination of environmental health hazards near people's homes and workplaces (Goals 1 and 2);
- Ensure the safety of food and drugs (Goal 2);

- Provide health services for elderly and disabled Americans, as well as low-income adults and children (Goal 3);
- Promote services that increase the proportion of older Americans who stay active and healthy (Goal 6);
- Provide financial assistance and employment support services for low-income families (Goal 6);
- Facilitate child support enforcement (Goal 7);
- Improve consumer and patient protections (Goal 5);
- Improve maternal and infant health (Goal 3);
- Increase the percentage of children and youth living in a permanent, safe environment (Goal 7);
- Prevent child abuse and domestic violence (Goal 7);
- Provide and improve substance abuse prevention and treatment services (Goal 1);
- Provide and improve mental health services (Goal 6); and
- Enhance the use of electronic commerce in service delivery and record keeping (Goal 8).

"One HHS"

HHS' management philosophy is to function as a single entity, as "One HHS," rather than as a collection of disparate and unrelated Agencies. HHS is reforming its management processes, updating the policies that maintain and strengthen the HHS workforce, and continuing to collaborate and coordinate significant activities among HHS Agencies. The importance of a one-team approach has been underlined by the extensive new demands on HHS and its Agencies to rapidly enhance preparedness against terrorism. HHS' FY 2004-2009 S*trategic Plan* contains a management improvement and excellence goal, which includes strategies to consolidate personnel offices; modernize and improve human, financial, and technology management at HHS; and reform regulations to reduce excessive paperwork and burden on doctors and hospitals so that they may have more time to deliver quality care. To provide accountability, feedback, and a record of progress, HHS has instituted performance contracts tied to the strategic goals and objectives for its senior leadership. These contracts establish explicit standards to measure HHS officials' progress and achievements, which will cascade throughout the Department.

HHS Partners - Working Together

HHS' ability to meet client needs and accomplish its goals is tied directly to the commitment, cooperation, and success generated by HHS employees and those of other Federal agencies, State and local governments, Tribal organizations, community-based organizations, faith-based organizations, and others.

HHS provides direct services for the underserved populations of America, including American Indians/ Alaska Natives. For many programs, HHS' partners provide direct services and have great discretion in program implementation. HHS supports its partners' goals and efforts by providing funding, technical assistance, outreach, education, training, research, and demonstration projects to test new programs, processes, or policies.

Often the needs of individuals and families transcend individual HHS program boundaries. HHS works internally and with its many diverse partners to coordinate service planning and delivery to optimize resource use. For example:

- HHS is the largest grant-making agency in the Federal Government, providing more than $240 billion of the more than $387 billion in Federal funds awarded to States and other entities in FY 2003;
- In FY 2001, HHS funded more than 200,000 research investigators affiliated with numerous universities, hospitals, and other research facilities;
- Approximately 19,200 centers and 47,000 classrooms help to provide comprehensive development services with HHS support under the Head Start program for more than 909,000 low-income preschool children, ages birth to 5, including more than 70,000 children under the age of 3 served through Early Head Start;
- HHS helps fund and foster a nationwide network of almost 3,600 community Health Center sites that provided primary and preventive care to 12.4 million medically-underserved patients last year;
- HHS partners with the Aging Network, which includes 56 State units on aging, 655 area agencies on aging, 236 Tribal and native organizations representing 300 American Indian/Alaska Native Tribal organizations, and two organizations serving Native Hawaiians, plus thousands of service providers and innumerable caregivers and volunteers;
- HHS supports networks of State and private agencies to provide and improve substance abuse and mental health services;
- HHS coordinates public health efforts to respond to multiple widespread disease outbreaks, including the West Nile virus epidemic, the global outbreak of Severe Acute Respiratory Syndrome (SARS), and the first U.S. human cases of Monkeypox;
- Medicare contractors process more than 1 billion Fee-for-Service (FFS) claims, answer numerous inquiries, process appeals, enroll and educate providers, and assist beneficiaries; and
- Approximately 45,000 health care providers are enrolled in the Vaccines for Children program, furnishing free vaccines to more than one-third of the Nation's children.

Steps to a HealthierUS

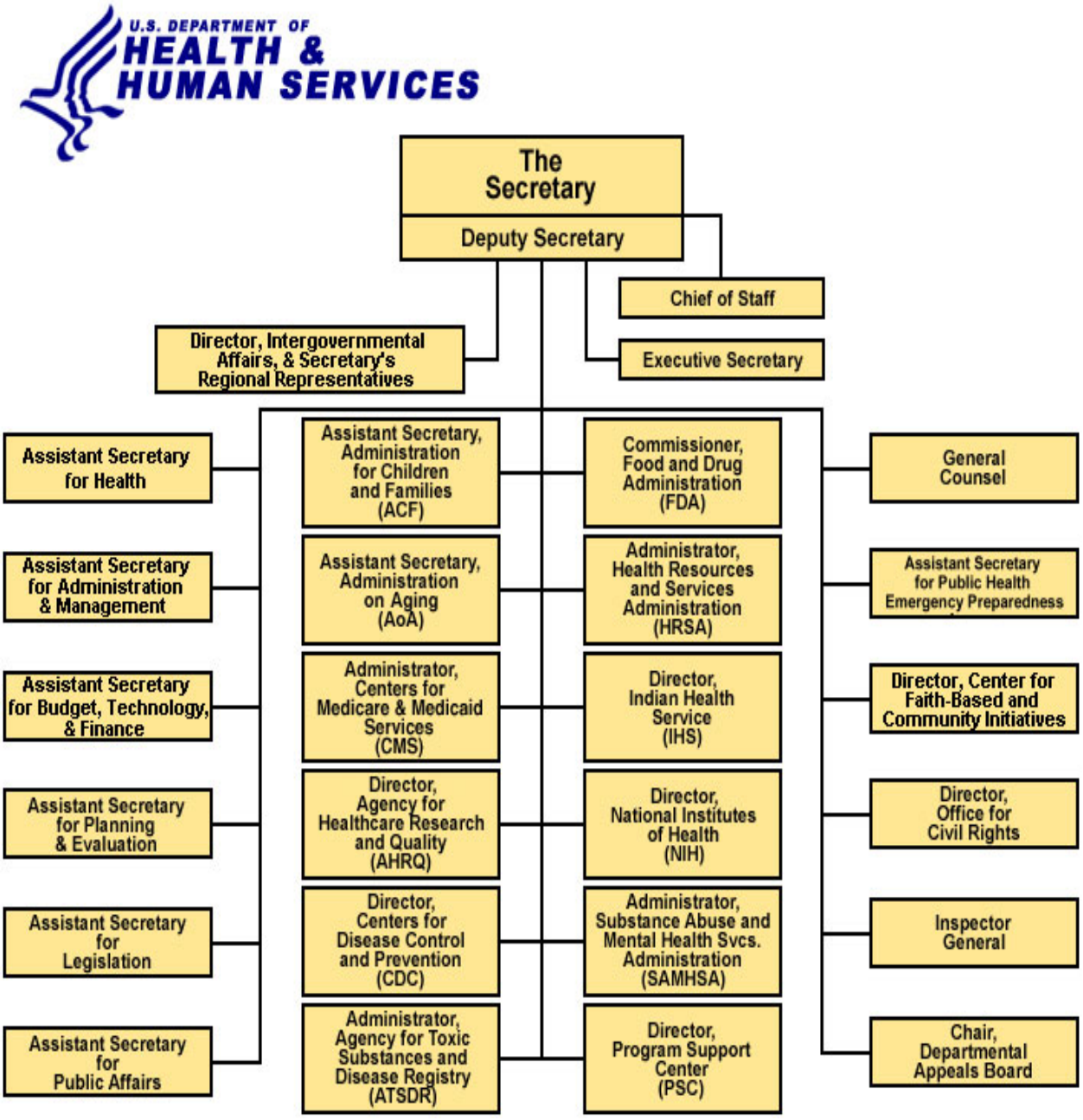
The value and benefits of partnership are particularly evident in the *Steps to a HealthierUS* initiative. *Steps to a HealthierUS* is the new prevention initiative that provides a blueprint for a healthy, strong Nation where diseases are prevented when possible, controlled as necessary, and treated as appropriate. Specifically, *Steps to a HealthierUS* targets diabetes, obesity, and asthma, and the associated lifestyle choices of nutrition, physical activity, and tobacco use. Many HHS Agencies participate in this program, and the centerpiece of this initiative is a cooperative agreement grant program that relies on public-private partnerships at the community level to support programs and activities that enable individuals to adopt healthy lifestyles that prevent or delay

chronic diseases. A national advertising campaign for this program began in 2004. More information on this initiative is available at www.healthierUS.gov.

HHS Organization - Structured to Accomplish the Department's Mission

Eleven HHS Agencies led by the Office of the Secretary provide a wide range of services and benefits. The Office of the Secretary consists of several staff divisions, including the Assistant Secretary for Budget, Technology, and Finance, which is responsible for producing this report. HHS also actively coordinates, in 10 regions throughout the U.S., the crosscutting and complementary efforts that are needed to accomplish its mission. The following pages provide a brief overview of HHS' organization and the purpose and accomplishments of each HHS Agency, as well as a twelfth HHS organization, the Program Support Center (PSC). The PSC provides administrative services to the Department. Agency highlights include a reference to the corresponding strategic goal supported.

U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201
1-877-696-6775
www.hhs.gov


U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
The Secretary
Deputy Secretary
Chief of Staff
Executive Secretary
Director, Intergovernmental Affairs, & Secretary's Regional Representatives
Assistant Secretary for Health
Assistant Secretary for Administration & Management
Assistant Secretary for Budget, Technology, & Finance
Assistant Secretary for Planning & Evaluation
Assistant Secretary for Legislation
Assistant Secretary for Public Affairs
Assistant Secretary, Administration for Children and Families (ACF)
Assistant Secretary, Administration on Aging (AoA)
Administrator, Centers for Medicare & Medicaid Services (CMS)
Director, 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
Assistant Secretary for Public Health Emergency Preparedness
Director, Center for Faith-Based and Community Initiatives
Director, Office for Civil Rights
Inspector General
Chair, Departmental Appeals Board

HHS Agency	HHS Agency Description and Highlights
Administration for Children and Families (ACF) www.acf.hhs.gov	ACF programs promote the economic and social well-being of families, children, individuals, and communities. Major ACF programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, and Head Start for preschool children. ACF also provides funds to help low-income families pay for child care, prevent child abuse and domestic violence, and support State programs through the Adoption Incentive program. Established in 1991 as a result of a merger of the Family Support Administration and the Office of Human Development Services, ACF has eight program offices and five staff offices that operate in Washington, DC, and 10 regional offices. A predecessor Agency, the Social and Rehabilitation Service, was created within the Welfare Administration in 1963.
	ACF Highlights: • The Adoption Incentive program authorizes funds to States that are successful in increasing the number of children adopted from the foster care system. The number of children being adopted has increased recently from 31,000 in 1997 to 49,000 in FY 2003. (Goal 7) • The Refugee and Entrant Assistance program has been extremely effective in assisting refugees, asylees, Cuban, and Haitian entrants become employed and self-sufficient by providing cash and medical assistance to financially-needy refuges as well as foster care services for minors. Between 1996 and 2001, the employment rate for those who arrived in the U.S has remained virtually the same as the employment rate for the U.S. population. (Goal 6) • The Federal Administration account includes funding for employee salaries and benefits and provides critical support to grants administration and to the PMA. ACF successfully obtained "green" ratings in all five PMA initiatives for every quarter in FY 2004. (Goal 8) • Record numbers of people are moving from welfare to work. All States met the overall work participation requirements in FY 2002 (in FYs 2002-2003, the family work participation rates for all States was 50 percent). (Goal 6) • Approximately 11.5 million child support cases and support orders were established out of 16 million cases in FY 2003. A record $1.6 billion in delinquent child support was collected in tax year 2003, representing a 23 percent increase since 1999. (Goal 7) • Children enrolled in the Head Start program had a 32 percent gain in word knowledge compared to an average gain of 19 percent among all children during the pre-Kindergarten year. (Goal 7)
Administration on Aging (AoA) www.aoa.gov	AoA is the Federal focal point for programs and services for the elderly and aging. Through policy and program development, planning, and service delivery, AoA seeks to address the needs and concerns of older people, their families, and their caregivers. AoA leverages its funds through a nationwide service infrastructure to deliver comprehensive in-home and community-based services, including nutrition services, to the elderly. AoA funds also make preventive health services, elder rights, and long-term care ombudsmen programs available to elderly Americans. Established in 1965, AoA partners with State and area agencies on aging, Tribal organizations, and service providers within the aging network to accomplish its mission.

HHS Agency	HHS Agency Description and Highlights
AoA (Continued)	AoA Highlights: • AoA and the Centers for Medicare & Medicaid (CMS), co-led the creation of Aging and Disability Resource Centers to provide consumers in 24 States with objective information about long-term care options and to help States create citizen-centered care systems by increasing community-based care choices and controlling costs. (Goal 6) • Launched an Evidenced-Based Disease Prevention program that will assist aging service provider organizations in 12 communities to translate research into practice by developing high-quality preventive interventions targeted to elderly individuals in five areas: falls prevention, physical activity, sound nutrition, medication management, and disease self-management. (Goal 1) • Increased the number of caregivers served through the National Family Caregiver Support program, which in FY 2003 provided: (1) caregiver program and service information to over 8 million people; (2) access assistance services to over 590,000 caregivers; (3) counseling and training services to over 300,000 caregivers; (4) respite to nearly 200,000 caregivers; and (5) supplemental services to over 220,000 caregivers. (Goal 6) • Assisted seniors to remain in their homes and communities by providing a variety of supportive and nutrition services in FY 2003, including almost 36 million rides to doctors offices, grocery stores, and other critical daily activities; almost 248 million congregate and home-delivered meals; and almost 20 million hours of in-home services such as personal care, homemaker, and chore services. (Goal 6)
Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov	AHRQ leverages its research and information-sharing programs to improve the quality, effectiveness, and accessibility of health care; and to reduce health care costs. AHRQ conducts and supports the research needed to guide decision making and improvements in both clinical care and health care organization and financing. Furthermore, it also promotes the incorporation of AHRQ's and other research-based information into effective health care choices and treatment by developing tools for public and private decision makers and by broadly disseminating the results of the research. Established in December 1989 as a Public Health Service Agency in HHS, the Agency for Healthcare Policy and Research was reauthorized as AHRQ on December 6, 1999. Located in Rockville, MD, AHRQ operates five centers and special policy and information offices.
	AHRQ Highlights: • Through the first year of the Patient Safety Improvement Corps, AHRQ trained more than 50 patient safety experts representing 15 States and 13 hospitals/major health care organizations to use tools and techniques to analyze health care-related errors, risks, and hazards; identify and understand their root causes; and identify and implement effective, evidence-based interventions to make the delivery of health care safer. (Goal 1) • AHRQ launched its web-based National Quality Measures Clearinghouse at http://www.qualitymeasures.ahrq.gov. The clearinghouse contains the most current evidence-based quality measures available to evaluate and improve the quality of health care. (Goal 5) • During 2004, AHRQ continued its support of the Mortality and Morbidity (M&M) website, http://webmm.ahrq.gov, a monthly peer-reviewed, web-based medical journal that showcases patient safety lessons drawn from actual cases of near misses (medical errors that result in no harm) to educate health care providers about medical errors in a blame-free environment. (Goal 1) • Agencies, grantees, and preparedness constituencies continue to use AHRQ bioterrorism research findings as a basis for planning activities, including: capacity, regional models of response and readiness, health care personnel training and disaster drills, information technology (IT) and communication technology for surveillance and response, medication and vaccination distribution, and facilities and equipment preparedness needs. (Goal 2).

HHS Agency	HHS Agency Description and Highlights
Agency for Toxic Substances and Disease Registry (ATSDR) www.atsdr.cdc.gov	ATSDR helps individuals protect their health from hazardous wastes that may be present in their environment. Since Love Canal in New York first brought the problem of hazardous wastes to light in the 1970s, thousands of hazardous waste sites have been identified around the country. The Environmental Protection Agency (EPA) National Priorities List targets more than 1,500 hazardous sites for clean up. The Comprehensive Environmental Response, Compensation, and Liability Act of 1980, more commonly known as the Superfund law, created ATSDR. The Superfund program is charged with finding and cleaning up the most dangerous hazardous waste sites in the country. Formally organized in 1985, ATSDR is responsible for carrying out the health-related portions of the Superfund law and of other laws that protect the public from hazardous wastes and spills of toxic substances. ATSDR is headquartered in Atlanta, GA, and has 10 regional offices. The Agency's multidisciplinary staff of about 435 employees includes epidemiologists, physicians, nurses, toxicologists, engineers, public health educators, and other specialists. ATSDR Highlights: • ATSDR continues efforts to help residents of Libby, Montana cope with the harmful effects of living with asbestos in their environment. From 1979 to 1998, mortality from asbestosis was nearly 40 times higher for Libby than for Montana in general, and 80 times higher than for the United States. In addition, mortality from lung cancer was found to be 20–30 percent higher than expected. To help those who were exposed, ATSDR provided medical screenings to approximately 7,300 current and former Libby residents and workers to identify potential asbestos-related health effects. Nearly 1,200 were found to have abnormalities in their lung lining, suggesting an increased risk of asbestos-related disease. ATSDR has worked to educate Libby residents and health professionals about asbestos and its hazards, and Montana's State health department is continuing to offer an asbestos-screening program, in part through ATSDR funding and technical assistance. (Goal 1) • ATSDR often conducts its site-related work with the assistance of its "cooperative agreement" partners: public health departments across the Nation that carry out the same type of public health work performed by ATSDR. The Agency provided technical help and funds – approximately $4.5 million in FY 2004 – for its partners to produce public health assessments, health consultations, health studies, and health education programs in communities near hazardous waste sites or spills. This investment helps ATSDR serve thousands more people than would be possible otherwise. (Goal 1)
Centers for Disease Control and Prevention (CDC) www.cdc.gov	CDC is the lead Federal agency responsible for protecting the health and safety of individuals at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States. Beginning in 2004, CDC will focus its efforts on two overarching goals: • Preparedness: People in all communities will be protected from infectious, environmental, and terrorist threats. • Health promotion and prevention of disease, injury, and disability: All individuals will achieve their optimal lifespan with the best possible quality of health in every stage of life. Established in 1946 as the Communicable Disease Center, CDC operates from its national headquarters in Atlanta, GA. CDC's workforce includes approximately 8,500 employees, including those in 47 State health departments and 45 countries.

HHS Agency	HHS Agency Description and Highlights
CDC (Continued)	CDC Highlights: • Through the Futures initiative, begun in 2003 and currently in implementation, CDC is changing to meet the challenges of public health in the 21st century. Modernizing CDC will enhance return on investment and positive health impact, support capacity to prepare for and contain public health emergencies, and directly engage CDC customers, the American public. (Goal 8) • CDC is focused on "establishing global health priorities," and continues to build both bilateral and multilateral relationships to facilitate more rapid flow of information and increase trust and confidence in CDC's shared ability to think, plan, and act in concert. Examples of the work CDC is doing in the global arena include Polio eradication; global Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) prevention, treatment, and support; global disease surveillance and response; and laboratory training. (Goal 1) • In FY 2004, CDC funded an estimated $5 billion for its extramural programs, including grants/cooperative agreements and research contracts. Extramural programs are those programs for which the actual work is done outside of CDC by such organizations as universities, nonprofits, community-based organizations, etc. The programs are widespread across CDC and address birth defects, chronic disease prevention, environmental health, HIV/AIDS, sexually-transmitted disease and Tuberculosis prevention, immunization (including Vaccines for Children), infectious disease control, injury prevention, public health improvement, and terrorism. (Goal 1) • CDC continues to support *Steps to a HealthierUS*, HHS' initiative to help Americans live longer, better, and healthier lives. In FY 2004, the initiative distributed $35.8 million to 22 grantees to implement community action plans that build on existing local, State, and Federal programming efforts related to obesity, Diabetes, Asthma, and their risk factors. (Goal 1)
Centers for Medicare & Medicaid Services (CMS) www.cms.gov	CMS administers the Medicare and Medicaid programs and the State Children's Health Insurance Program (SCHIP), all of which provide health care for about one in four Americans. These programs' combined outlays, including State funding, represent about a third of every dollar spent on health care in the United States, making CMS one of the largest purchasers of health care in the world. Medicare provides health care coverage for elderly and disabled Americans. Medicaid, a joint Federal-State program, provides health coverage for low-income persons (almost half of enrollees are children), and also pays for nursing home coverage for low-income elderly. The SCHIP, a Federal-State program, provides health insurance coverage for children who otherwise would be without coverage. CMS operates from Baltimore, MD; Washington, DC; and 10 regional offices.

HHS Agency	HHS Agency Description and Highlights
CMS (Continued)	CMS Highlights: • The Medicare Prescription Drug Discount Card and Transitional Assistance program was enacted on December 8, 2003 as part of the Medicare Modernization Act of 2003. The Drug Discount Card program enables eligible Medicare beneficiaries to obtain discounts of 10 to 25 percent on prescription drugs. This program is not intended to be a prescription drug benefit, but rather a measure to help people until the drug benefit is implemented on January 1, 2006. Over 4 million people with Medicare had enrolled in the program by mid-July 2004. The estimated amount of savings will be available after the end of the calendar year. (Goal 3) • Medicare will provide a $600 credit for the purchase of prescription drugs in 2004 and up to an additional $600 credit in 2005 to people with incomes that are not more than 135 percent of the poverty line ($12,569 for single individuals or $16,862 for married individuals in 2004—these income levels will vary slightly for subsequent years) if they do not have certain other drug coverage. Of the more than 4 million enrolled in the discount drug card program, nearly 1 million are receiving the $600 credit. (Goal 3) • In the Medicaid program, CMS continues to allow States greater flexibility to design health insurance programs to meet the health care needs of their low-income and children populations. (Goal 3) • The CMS is nearing completion of the development of the Health Care Integrated General Ledger Accounting System (HIGLAS) that incorporates Medicare FFS contractor financial data (including claims activity) into the CMS internal accounting system. Implementation of the Joint Financial Management Improvement Program (JFMIP)-certified commercial off-the-shelf product, developed by the Oracle Corporation, is expected to commence next fiscal year. (Goal 8)
Food and Drug Administration (FDA) www.fda.gov	FDA is a science-based regulatory Agency whose mission is to promote and protect public health and well-being by ensuring that safe and effective products reach the market in a timely manner, and to monitor products for continued safety once in use. FDA is divided into six program areas: (1) foods, (2) drugs, (3) biological products, (4) veterinary medicine, (5) medical devices, and (6) toxicological research. Each program area, except for toxicological research, is responsible for ensuring the safety and, where applicable, the effectiveness of products through their entire life cycle, from initial research through manufacturing, distribution, and consumption. These programs, supported by a national field force of scientific investigators, also monitor the safety of more than 7 million import shipments that arrive at America's borders each year. The Toxicological Research program conducts peer-reviewed research that provides the basis for FDA to make sound, science-based regulatory decisions. Established in 1927 (Congress passed the Food and Drug Act in 1906), FDA is headquartered in Rockville, MD, and is organized into six program centers, two offices, and five regions nationwide.

HHS Agency	HHS Agency Description and Highlights

FDA (continued)	FDA Highlights:
	• On August 23, 2003, FDA created an Obesity working group and issued a report outlining an action plan to cover critical dimensions of this problem. On March 12, 2004, Secretary Thompson released a new report produced by the group, outlining another element in HHS' comprehensive strategy for combating the epidemic of obesity. Secretary Thompson said, "Counting calories is critical for people trying to achieve and maintain a healthy weight." (Goal 1)
	• Velcade (bortezomib), a new cancer treatment for multiple myeloma, a cancer of the bone marrow, received fast-track approval under FDA's accelerated New Drug Application Approval program in less than 4 months. Velcade is the first in a new class of anticancer agents known as proteasome inhibitors. (Goal 5)
	• The Food Emergency Response Network integrates the Nation's laboratory infrastructure for the detection of threat agents in food at the local, State, and Federal levels. Network laboratories are responsible for the detection and identification of biological, chemical, and radiological agents in food. The network's primary objectives include:
	  • Prevention (Federal and State surveillance sampling programs to monitor the food supply);
	  • Preparedness (strengthen laboratory capacity and capabilities);
	  • Response (surge capacity to handle terrorist attacks or a national emergency involving the food supply); and,
	  • Recovery (support recalls, seizures, and disposal of contaminated food to restore confidence in the food supply). (Goal 2)

Health Resources and Services Administration (HRSA) www.hrsa.gov	HRSA, an important component of the Nation's health care safety net, improves the Nation's health by helping to assure equitable access to comprehensive, quality health care. HRSA and its State, local, and other partners work to eliminate barriers to care and health disparities for Americans who are underserved, vulnerable, and have special needs. Established in 1982 and located in Rockville, MD, HRSA operates through five bureaus and several offices to support comprehensive primary care services, decrease infant mortality, improve maternal and child health, provide services to people with AIDS through the Ryan White Comprehensive AIDS Resources Emergency (Ryan White CARE) Act programs, oversee the Nation's organ transplantation and bone marrow donor systems, and help hospitals and health care workers prepare in the event of bioterrorism or other mass public health emergency. HRSA also helps build a well-qualified health care workforce and maintains the National Health Service Corps.
	HRSA Highlights: • Through the Ryan White CARE Act's State AIDS Drug Assistance program, nearly 81,200 individuals received essential HIV/AIDS medications during at least 1 month of the year in FY 2002, exceeding the previous year's number by about 7,400 persons. (Goal 3) • In FY 2003, more than 78 percent of National Health Service Corps clinicians remained in service to underserved areas for at least 1 year following completion of their service contracts. (Goal 3)

HHS Agency	HHS Agency Description and Highlights
Indian Health Service (IHS) www.ihs.gov	IHS is the principal Federal health care provider and health advocate for American Indian/Alaska Native people. In partnership with American Indians/Alaska Natives from more than 562 Federally recognized Tribes, IHS' mission is to raise the physical, mental, social, and spiritual health of American Indians/Alaska Natives to the highest level. IHS and the Indian Tribes are responsible for serving 1.6 million American Indians/Alaska Natives through direct delivery of local health services. At the current time, American Indian/Alaska Native people experience the lowest life expectancy in the country. IHS was established in 1924; its mission was transferred from the Department of the Interior in 1955. IHS funds hospitals, Health Centers, school health centers, and health stations, which are administered by Indian Tribes directly or by IHS. There are also 34 health programs operated by urban Indian Health Organizations that provide various services to American Indians/Alaskan Natives living in urban areas of the country. When health care services are unavailable from IHS or the Indian Tribes, IHS purchases medical services from other providers to ensure delivery of needed care. IHS is headquartered in Rockville, MD, and its 12 area offices are further divided into service units for reservations or population concentrations.
	IHS Highlights: • Developed the Indian Health Service Electronic Health Record, a robust integrated health information system in a graphical user format, at health care test sites. (Goal 5) • Monitored diabetic control in over 75 percent of diagnosed diabetics on a routine basis in FY 2003 and FY 2004 (CDC's Healthy People 2010 initiative, which contains a set of heatlh objectives for the Nation to achieve over the first decade of this century, set a goal of 50 percent monitoring). (Goal 3) • Demonstrated through the IHS Joslin Vision Network diabetic retinal screening program that a higher retinal screening rate could be achieved and maintained for diabetic patients at sites that participated in this program. (Goal 3) • Developed and implemented GPRA+ , a performance data collection system, at all clinical sites using the IHS health information system, facilitating the electronic review of over 1.1 million charts for clinical quality during FY 2003. (Goal 5)
National Institutes of Health (NIH) www.nih.gov	NIH is the world's premier medical research organization, supporting projects nationwide in diseases such as cancer, Alzheimer's, diabetes, arthritis, heart ailments, and AIDS. NIH Institutes and Centers improve the health of all Americans by advancing medical knowledge and sustaining the Nation's medical research capacity in disease diagnosis, treatment, and prevention. More than $8 out of every $10 appropriated to NIH flows out to the scientific community at large. NIH's research activities extend from basic research that explores the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention, and to population-based analyses of health status and needs. Established in 1887 as the Hygienic Laboratory in Staten Island, NY, NIH provides scientific leadership and establishes research priorities, funds the best research in the scientific community at large, and conducts leading-edge research in its laboratories. NIH also disseminates scientific results and information, facilitates the development of health-related products, ensures a continuing supply of well-trained laboratory and clinical investigators, sustains the Nation's research facilities, and collaborates with other Federal agencies. NIH is located in Bethesda, MD.

HHS Agency	HHS Agency Description and Highlights
NIH (Continued)	NIH Highlights: • NIH scientists developed a flea-to-mouse Plague transmission model for use in testing new candidate vaccines against the flea-borne Plague. This model mimics the natural transmission route of Bubonic Plague through the bite of infected fleas, thus providing a more realistic way to assess a vaccine's ability to protect against a real-world challenge. (Goal 4) • 7.8 million single nucleotide polymorphisms (SNPs), more than double the planned 3 million, have been identified and released in public databases. These additional SNPs substantially increased the density in public databases, thus facilitating development of the haplotype map (HapMap). (Goal 4) • NIH scientists have performed ongoing data analysis of the SNPs and have upgraded their estimate on their quality and completeness. The new estimate indicates that 95 percent of the discovered SNPs are valid. (Goal 4)
Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov	SAMHSA is the lead Federal agency for substance abuse and mental health services, enabling service capacity expansion and the implementation of evidence-based practices. SAMHSA provides services indirectly through grants and contracts to nonprofit organizations, universities, government agencies, and Indian Tribes for children, adolescents, and adults. SAMHSA administers two block grants that provide funding to States and territories for direct substance abuse and mental health services, as well as discretionary grants for other recipients. SAMHSA was established in 1992 from a predecessor Agency, the Alcohol, Drug Abuse and Mental Health Administration that was established in 1974. Located in Rockville, MD, SAMHSA is organized into the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment, as well as two program offices, the Office of the Administrator and the Office of Applied Studies.
	SAMHSA Highlights: • Implemented new grant program, Access to Recovery, to fund voucher programs for substance abuse clinical treatment and recovery support. This program is part of a Presidential initiative to provide client choice among substance abuse clinical treatment and recovery support service providers, expand access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increase substance abuse treatment capacity. (Goal 1) • Developed the Strategic Prevention Framework to decrease substance use and abuse, promote mental health, prevent mental disorders, and reduce disability, co-morbidity, and relapses related to substance use/abuse and mental illness. The framework changes SAMHSA's approach to prevention and helps move the President's vision of a healthier U.S. to State and community-based action. (Goal 1) • Published FY 2004/2005 action plans for each of SAMHSA's matrix area priorities (substance abuse treatment capacity, strategic prevention framework, mental health system transformation, co-occurring disorders, seclusion and restraint, children and families, disaster readiness and response, homelessness, aging, HIV/AIDS and Hepatitis, and criminal justice). (Goal 1) • SAMHSA is developing a full internal enterprise model to identify data gaps, eliminate redundancies, and improve the underlying technology. This internal enterprise architecture will link to the HHS enterprise architecture. SAMHSA also has developed a set of national outcomes that will be measured in SAMHSA's major programs, including its State-administered block grants and its major discretionary programs. (Goal 1)
Program Support Center (PSC) (Administrative office)	Established in 1995 as a Working Capital Revolving Fund under the Department's Service and Supply Fund, the PSC is an administrative support center. The PSC is organizationally aligned under the Assistant Secretary for Administration and Management, Office of the Secretary, and provides a full range of program support services to all components of HHS and other Federal agencies through FFS. PSC's major business lines include administrative operations, financial management, acquisition services, health resources, and human resource systems.

Program Performance Overview

A Focus on Outcomes

HHS manages hundreds of programs that serve to improve the health and well-being of the American public. Secretary Thompson established eight strategic goals that incorporate the full range of HHS' activities. To gauge program effectiveness, HHS uses hundreds of performance measures. These measures provide a basis for comparing actual program results with established program performance goals, as required by the Government Performance and Results Act (GPRA) of 1993. Given the complexity and vast number of HHS programs and measures, HHS, with OMB's concurrence, focuses on 22 program areas and 29 measures in this report that broadly represent HHS' significant efforts and achievements during FY 2004. The programs, which include Bioterrorism, Immunization, Medicare, Medicaid, Children's Health Insurance, Child Welfare, Substance Abuse Prevention and Treatment, and Medical Research, and their corresponding measures, are presented according to the strategic goal each supports. The corresponding measures highlight progress and discuss issues pertaining to the goals, objectives, and targets articulated in the HHS *Strategic Plan* as well as other HHS initiatives.

Performance Data Collection and Reporting

The Department's FY 2004 *Program Performance Report* is presented in Section II and summarized in the following pages. The following overview provides readers with a sense of the far-reaching effects of HHS programs. Focusing on performance over the past 3 fiscal years (FYs 2002 - 2004), each program discussion "spotlights" one of the critical performance measures by explaining its purpose and highlighting its performance and accomplishments. The "spotlighted" section is highlighted in the list of measures for each strategic goal. Performance for each "spotlight measure" is summarized in a table that presents a target and either the corresponding actual data or the expected date when actual data will become available. Additional information on the "spotlight" and other measures is included in Section II of this report.

Section II provides a detailed discussion of performance results for each of the 29 measures referenced in the overview, including additional trend data, individual Agency efforts taken to ensure relevance and reliability of the data reported, and results of any independent program evaluations and program reviews, including those under OMB's Program Assessment Rating Tool (PART). The PART is a diagnostic tool that examines different performance aspects to identify a program's strengths and weaknesses; it also supports the Administration's efforts to improve program effectiveness and to inform budget decisions. The results of PARTs completed during the FY 2004 and FY 2005 budget processes are summarized in Appendix I, and the comparative net costs of these and other HHS GPRA programs are presented in Appendix B.

Performance data availability lags occur, particularly in HHS programs that rely on third parties (e.g., States, grantees, and medical facilities) for such data. In addition, not all data are collected or available annually. Therefore, an assessment of HHS performance can best be determined by comparing annual trends from year to year, as additional performance data become available. HHS uses the same data collection systems to report on both Department- and HHS Agency-level performance. Assurance of the accuracy of performance data reported in Section II and in this section of the report is achieved through data verification processes inherent in the recurring use and updates of the data. Analysts, managers, and executives in both the Agencies and in HHS' Office of Budget verify the data on an ongoing basis. The data receive a final review in the Office of Budget by budget and program branch chiefs with budget and performance responsibilities prior to submission and final review by the Deputy Assistant Secretary for Budget. Performance management and assessment activities related to the GPRA, PART, and other

performance-related activities include assurances of the accuracy of data, which are documented in the Data Verification and Validation sections of the Agencies' annual performance plans and reports.

Risks and Uncertainties Affecting Performance

Many external factors and influences beyond HHS' control may affect achievement of the Department's strategic goals and objectives. These factors introduce risks and uncertainties into the Department's planning environment and may, in some cases, pose challenges that are difficult to overcome.

Even during the best of economic times, health and social services must compete with other worthy interests for limited public funds. For example, the public health infrastructure received new infusions of funds following September 11, 2001, to address bioterrorism and other threats. While this offers opportunities for building needed surveillance systems and communication links, unexpected threats such as SARS continue to emerge and require immediate action, diverting attention from activities with a longer term. In addition, a weak economy can impact individuals by making finding jobs more difficult and can affect families seeking to become economically independent.

Individuals' choices about personal health habits (e.g., exercise, diet, or smoking) have a cumulative effect on the incidence of chronic disease. While the Department has many current activities addressing lifestyle health choices, its prevention initiative, *Steps to a HealthierUS*, seeks to help States, large and small communities, and Tribes build on their existing efforts to address diabetes, asthma, and obesity and the associated risk factors of tobacco use, poor nutrition, and inactivity, in organized sustained ways that can ultimately serve as models for wider use.

Providing flexibility in program requirements enables HHS to address changing and unpredictable conditions. For instance, HHS has offered States greater choice in Medicaid and SCHIP program design through the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. This flexibility allows States to adapt their Medicaid programs, within the framework of existing law, to their unique needs. HHS has sought and received major new funding to address public health infrastructure needs and is working with State and local public health officials, hospitals, and other providers to build the necessary surveillance systems and communication networks.

Additional Performance Information

HHS Agencies annually prepare individual performance plans and reports that collectively address all of the Department's program performance measures in greater detail and in support of HHS' *Strategic Plan*. This information is available at the following locations on the HHS website (http://www.hhs.gov/):

- HHS performance goals, objectives, and measures, (the HHS *Strategic Plan*) at http://aspe.hhs.gov/hhsplan/
- HHS performance plans and reports can be found at http://www.hhs.gov/budget/docgpra.htm. HHS Agency-level plans and reports may be accessed through the individual Agency websites referenced earlier in the preceding section.

Strategic Goal 1:

Reduce the Major Threats to the Health and Well-being of Americans

Research indicates that premature mortality and morbidity in the United States can be significantly prevented if individuals avoid certain high-risk behaviors, adopt healthy lifestyles, and reduce exposure to major environmental health risks. HHS' pursuit of this goal focuses on changing behaviors and reducing risks associated with the leading causes of premature mortality and morbidity in the United States. It also includes such critical efforts as increasing immunization rates among children and adults, decreasing substance abuse, and reducing the incidence of sexually-transmitted diseases.

The following table summarizes representative metrics used by the responsible HHS Agency to evaluate the success of these programs and progress toward achieving the strategic goal.

PERFORMANCE MEASURES		AGENCY / PROGRAM
1a	Achieve or sustain immunization coverage of at least 90% in children 19- to 35- months of age for [1]: 4 doses DTaP (Diptheria-Tetanus-acellular Pertussis) vaccine [2] 3 doses Hib (Haemophilus Influenzae type b) vaccine 1 dose MMR (Measles, Mumps, Rubella) vaccine [3] 3 doses Hepatitis B vaccine 3 doses Polio vaccine 1 dose Varicella vaccine [4] 4 doses Pneumococcal conjugate vaccine (PCV7) [4].	CDC / National Immunization Program
1b1	Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age. [5, 6]	CDC / HIV/AIDS Prevention in the US
1b2	Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 235 cases.	
1c	Number of clients served.	SAMHSA / Substance Abuse Prevention and Treatment Block Grant
1d1	Increase annual Influenza vaccinations in Medicare beneficiaries age 65 and older to 72.5% over baseline (FY 1994 –59%).	CMS / Quality Improvement Organization Program
1d2	Increase lifetime Pneumococcal vaccinations in Medicare beneficiaries age 65 and older to 69% over baseline (FY 1994 – 24.6%).	

[1] Data are collected through the National Immunization Survey and reflect calendar years.
[2] Due to a shortage of vaccine and temporary change in recommendations, reported three doses from 2002 – 2003.
[3] Includes any Measles-containing vaccine.
[4] Performance targets for newly recommended vaccines are reported in GPRA 5 years after Advisory Committee on Immunization Practices (ACIP) recommendation. Measures for Varicella began in 2001. Performance reporting for PCV7 will begin in 2006.
[5] CDC will continue to revise baseline and targets when data from more States with adequate HIV reporting systems are available.
[6] Data are from 25 States with confidential, name-based HIV reporting. Beginning in 2006, all reported data will be from 30 areas with confidential, name-based HIV reporting.

HHS has implemented many programs to ensure that major threats to the health of American citizens are addressed on a national level. Some of the highlighted programs include CDC's National Immunization

program, which protects the health of children and adults through the development and implementation of vaccination programs and strategies. CDC is also the Federal agency charged with preventing HIV infection, and it engages in a variety of prevention activities including surveillance, research, intervention, capacity building, and evaluation. SAMHSA's Substance Abuse Prevention and Treatment Block Grant program works to improve the well-being of Americans by bringing effective alcohol and drug treatment and prevention services to every community through a block grant to the States. CMS' Quality Improvement Organization program helps Americans by ensuring that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. Quality Improvement Organizations work with beneficiaries, providers, managed care plans, community groups, and other interested partners to design and implement immunization quality improvement projects for illnesses such as Influenza and Pneumococcal Pneumonia.

Accomplishments in CDC National Immunization program are spotlighted below and on the following page.

SPOTLIGHT: NATIONAL IMMUNIZATION PROGRAM (CDC)

PERFORMANCE MEASURE:	Achieve or sustain immunization coverage of at least 90 percent in children 19- to 35- months of age for[1]: 4 doses DTaP vaccine[2], 3 doses Hib vaccine, 1 dose MMR vaccine[3], 3 doses Hepatitis B vaccine, 3 doses Polio vaccine, 1 dose Varicella vaccine[4], 4 doses PCV7[4].		
	FY 2002	FY 2003	FY 2004
Target	90% immunization coverage	90% immunization coverage	90% immunization coverage
Actual	DTaP: 95% Hib: 93% MMR: 91% Hepatitis B: 90% Polio: 90% Varicella: 81%	DTaP: 96% Hib: 94% MMR: 93% Hepatitis B: 92% Polio: 92% Varicella: 85%	Data available 08/2005

[1] Data are collected through the National Immunization Survey and reflect calendar years.
[2] Due to a shortage of vaccine and temporary change in recommendations, reported three doses from 2002 – 2003.
[3] Includes any Measles-containing vaccine.
[4] Performance targets for newly recommended vaccines are reported in GPRA 5 years after ACIP recommendation. Measures for Varicella began in 2001. Performance reporting for PCV7 will begin in 2006.

SPOTLIGHT: NATIONAL IMMUNIZATION PROGRAM (CDC)

Through the National Immunization program, CDC protects the health of children and adults from disability and disease associated with vaccine-preventable diseases by developing and implementing immunization programs and monitoring vaccine use.

One of CDC's immunization goals is to ensure that 2-year-olds are appropriately vaccinated. New cases of most vaccine-preventable disease have decreased approximately 99 percent from peak pre-vaccine levels, which has saved lives and reduced treatment and hospitalization costs. As CDC's immunization activities increase childhood immunization coverage, the incidence of vaccine-preventable diseases declines significantly. Vaccination coverage levels are at 90 percent or higher for most individual vaccines such as Measles, Polio, Hib, Hepatitis B, and three doses of DTaP. Examples of the success of immunizations include:

- Measles is a highly infectious, viral illness that can cause severe Pneumonia, diarrhea, Encephalitis, and death. Measles is no longer endemic in the United States.
- Only one child in the U.S. was born with Congenital Rubella Syndrome in 2003.
- Rubella cases have declined from 57,600 in 1969, when the vaccine was first available, to a total of seven cases in 2003.
- Hib cases have dropped more than 99 percent among children younger than age 5 since the Hib vaccine was introduced in 1990, and it is no longer the leading cause of Meningitis among children younger than 5 years of age in the U.S.
- There have not been any cases of Polio reported in the U.S. since 1979.

In 1996, the ACIP introduced the Varicella vaccine to the Recommended Childhood Immunization Schedule. By 2003, Varicella vaccine coverage levels reached almost 85 percent among most* racial and ethnic groups compared to a 26 percent coverage level in 1997.

ACIP added PCV7 to the 2001 Recommended Childhood Immunization Schedule. Reporting for the PCV7 performance target begins in FY 2006. PCV7 is already impacting the incidence of invasive Pneumococcal disease. According to a recently published study, the incidence of invasive Pneumococcal disease was 77 percent lower among white children less than 2 years of age and 89 percent lower among black children less than 2 years of age in 2002, as compared to 1998-1999 averages. Overall, this vaccine is projected to prevent more than 1 million episodes of childhood illness and approximately 120 deaths among children annually. Preventing Pneumococcal infections with vaccine is becoming more important because of problems with treatment as a result of increasing antibiotic resistance.

* Only American Indians/Alaska Natives had a coverage rate of 81 percent, which is below the national average for Varicella vaccine.

Strategic Goal 2:

Enhance the Ability of the Nation's Health Care System to Effectively Respond to Bioterrorism and Other Public Health Challenges

The September 11, 2001 terrorist attacks and the subsequent Anthrax attacks have focused attention on the prospect of the deliberate release of biological agents to cause major disease outbreaks. Of particular concern is the possibility of terrorist incidents aimed at civilians. To respond to any future bioterrorist attack, the U.S. needs a strong public health network (e.g., hospitals, health networks, physicians, nurses, mental health workers, and public health officials) to piece together early reports of a suspected attack, quickly determine what happened, and mount an effective response to care for casualties and prevent further exposure. This goal addresses the need to improve America's network of infectious disease surveillance, including improving communications, upgrading laboratory facilities, developing advanced diagnostic techniques, and expanding emergency health care training.

The following table summarizes key metrics used by the responsible HHS Agency to evaluate the success of these programs and progress towards achieving the strategic goal.

PERFORMANCE MEASURES		AGENCY / PROGRAM
2a1	Enhance preparedness by ensuring State, territorial, and local jurisdiction projects have written plans to respond to biological, chemical, radiological, and mass trauma hazards related to terrorism.	CDC / Terrorism Preparedness and Emergency Response Program
2a2	100 percent of State public health agencies improve their capacity to respond to exposure to chemicals or Category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified. [1]	
2b	Increase the percent of awardees that have developed plans to address surge capacity to 100 percent.	HRSA / Bioterrorism Hospital Preparedness Program
2c	Perform 60,000 import field exams and conduct sample analyses on products with suspect histories.	FDA / Foods Program

[1] CDC and OMB established this measure during the FY 2005 PART review of the Division of State and Local Readiness. Though work has begun, actual progress regarding the performance measure will be reported beginning in December 2005.

HHS plays a major role in helping the U.S. effectively respond to bioterrorism and other public health challenges. Among the Department's various initiatives, a few programs stand out. CDC's Terrorism Preparedness and Emergency Response program and Strategic National Stockpile program are designed to ensure that the U.S. has the plans and resources to support local, Statewide, and regional responses to incidents of bioterrorism, infectious disease outbreaks, and other public health threats and emergencies. In conjunction with this effort, HRSA's Bioterrorism Hospital Preparedness program is aimed at readying hospitals and supporting health care systems so that they are able to deliver coordinated and effective care to victims of terrorism and other public health emergencies. And finally, FDA's Foods program, spotlighted in detail on the next page, aims to ensure the safety of the U.S. food supply.

SPOTLIGHT: FOODS PROGRAM (FDA)

PERFORMANCE MEASURE:	Perform 60,000 import field exams and conduct sample analyses on products with suspect histories.		
	FY 2002	FY 2003	FY 2004
Target	Increase food import surveillance by hiring 300 new investigators and analysts who will increase the number of import field exams by 97% to 24,000 exams and conduct sample analyses on products with suspect histories	Increase exams by 100% to 48,000 exams	60,000 exams
Actual	Hired 600 new investigators and analysts 34,447 exams conducted	78,659 [1] exams	70,926 exams

[1] The FY 2003 unanticipated increase was due to Operation Liberty Shield, a one-time multi-department, multi-agency national plan that allowed FDA to leverage its resources with its State and other Federal Government partners, allowing it to achieve this high level of performance.

The Foods program promotes and protects the public's health by ensuring that the U.S. food supply is safe, sanitary, wholesome, and honestly labeled, and that cosmetic products are safe and properly labeled. The program regulates all food except meat, poultry, and frozen and dried eggs, which are regulated by the U.S. Department of Agriculture. As a result of the terrorist attacks of September 11, 2001, and the passage of the Bioterrorism Act of 2002, the program focused more intently on food security and defense so that the Nation's food supply, which is among the world's safest, would remain so.

The program regulates $417 billion worth of domestic food, $49 billion worth of imported foods, and $59 billion (including $4 billion imported) worth of cosmetics and toiletries sold across State lines. This regulation takes place from the products' point of U.S. entry or processing to their point of sale, with approximately 60,000 food establishments (including more than 33,000 U.S. food manufacturers and processors and over 22,000 food warehouses) and 2,600 cosmetic firms..

Starting in FY 2004, FDA expects that the counterterrorism staff brought on board in FYs 2002 and 2003 will have achieved the training and experience necessary to perform import activities. The Agency will continue to better target its import examination resources toward shipments that are believed to be at greater risk for safety and security concerns.

The FY 2004 performance target was to conduct 60,000 import field exams. FDA exceeded this target by achieving 70,926 import field exams.

While the original performance target for FY 2003 was 48,000 exams, FDA performed a total of 78,659 exams in that year due largely to the extraordinary effort under the Operation Liberty Shield, a one-time multi-department, multi-agency national exercise designed to increase protections for America's citizens and infrastructure. The FY 2004 target was adjusted to 60,000 exams to reflect resource changes and new requirements for implementing the Bioterrorism Act of 2002. Regardless of the increase, FDA continues to believe the best approach is to devote resources to better targeting and following through on suspect import entries rather than significantly expanding import coverage.

Strategic Goal 3:

Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care Services, and Expand Consumer Choices

In addition to changing behavior and reducing environmental health risks, improving health in the U.S. involves ensuring that everyone has access to health care, regardless of their geographic location or financial situation. Overall, approximately 44 million persons in the U.S. lack health insurance, and approximately 20 percent of America's population live in areas designated as having a shortage of health professionals to deliver primary medical care. Many families cannot afford the cost of care for children with special health care needs, and without financial support for the cost of drug therapies and associated services, access to treatment for persons with HIV/AIDS can be limited. HHS addresses these challenges through a variety of entitlement and safety net programs, such as Medicare, Medicaid, SCHIP, and Community Health Centers that provide access to health care for uninsured and low-income individuals.

The following table summarizes key metrics used by the responsible HHS Agencies to evaluate the success of these programs and progress towards achieving the strategic goal.

PERFORMANCE MEASURES		AGENCY / PROGRAM
3a	By the end of calendar year (CY) 2004 (FY 2005), improve satisfaction of Medicare beneficiaries with the health care services they receive in Managed Care (MC) and FFS over CY 2000 baseline: MC access to care – 93.0% (Baseline 90.5%), MC access to specialist – 86.0% (Baseline 83.7%), FFS access to care – 95.0% (Baseline 92.8%), FFS access to specialist – 85.0% (Baseline 82.8%).	CMS / Medicare
3b	Increase the number of children enrolled in regular Medicaid or SCHIP.	CMS / Medicaid and State Children's Health Insurance Program (SCHIP)
3c1	Increase the infrastructure of the Health Center program to support an increase in utilization, via new or expanded sites.	HRSA / Health Center Program
3c2	Increase number of uninsured and underserved persons served by Health Centers.	
3c3	Continue to assure access to preventive and primary care for racial/ethnic minorities (number and percent of total clients).	
3d	Increase the proportion of patients with diagnosed diabetes that have demonstrated improved glycemic control.	IHS / National Diabetes Program
3e	Implement the new Medicare-Endorsed Prescription Drug Card.	CMS / Medicare

HHS has implemented many successful programs to ensure that every citizen has affordable and accessible health care. Medicare, the Nation's largest and most important health insurance program, covers approximately 42 million Americans. While Medicare provides health insurance to people age 65 and over, other programs such as Medicaid and SCHIP are the primary sources of health care for a much larger population of medically-vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care.

Other important programs include IHS' National Diabetes program, which works with communities to prevent and treat diabetes among American Indian/Alaska Native populations, and HRSA's Health Center program, spotlighted below, which aims to increase health care access for those Americans most in need.

SPOTLIGHT: HEALTH CENTER PROGRAM (HRSA)

PERFORMANCE MEASURE:	Increase number of uninsured and underserved persons served by Health Centers.		
	FY 2002	FY 2003	FY 2004
Target	11.8 million	12.5 million	13.2 million
Actual	11.3 million	12.4 million	Data Available 08/2005

The Health Center program is a major component of America's health care safety net for the Nation's indigent, underserved, and vulnerable populations. This program, which is more than 35 years old, is a Presidential initiative to increase health care access for those Americans most in need. Millions of Americans lack access to a regular source of health care because they are either uninsured or face other non-financial barriers to obtaining needed care, such as geographic or linguistic barriers. Health Centers aim to provide regular access to high quality, family-oriented, and comprehensive primary and preventive health care regardless of patients' ability to pay while also reducing other barriers to care. The ultimate goal of the Health Center program is to improve the health status of underserved and vulnerable populations and to eliminate health disparities. The program provides grants to a variety of community-based public and private nonprofit organizations for the operation of Health Centers.

Growth in the number of persons served by Health Centers is an indicator of expanded access to care for the Nation's most vulnerable populations. The Health Center program served 12.4 million persons in 2003, achieving more than 99 percent of its target. This represented a growth of more than 1 million persons over the previous year, one of the largest single-year increases in the program's history and the second consecutive year in which the number of persons served rose by 1 million persons or more. FY 2004 information is expected in August 2005.

A PART review of the Health Center program was conducted for the FY 2004 budget. The program received the highest possible rating of "Effective." The assessment found that:

- The program purpose is clear and designed to have a unique and significant impact;
- The program uses performance information to improve annual administrative and clinical outcomes; and
- The program is making progress in achieving its long-term outcome goals.

Strategic Goal 4:

Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise

This goal recognizes the prominence of health research in HHS and its importance in furthering the overall mission of improving the Nation's health. While research is inherent within many other HHS goals, this goal focuses on creating knowledge that ultimately is useful in addressing health challenges and the need to maintain and improve the research infrastructure that produces scientific advances. HHS has implemented many successful programs to enhance the capacity and productivity of the Nation's health science research enterprise and NIH is one of its most important Agencies in this endeavor.

The following table provides a representative, trans-NIH goal that contributes to the achievement of this HHS strategic goal.

	PERFORMANCE MEASURES	AGENCY / PROGRAM
4a	Performance Goal: By 2005, create the next generation map of the human genome, a so-called haplotype map (HapMap), by identifying the patterns of genetic variation across all human chromosomes. FY 2004 Target: Collect samples from populations in Japan, China, and Nigeria; and complete collection of additional 3 million single nucleotide polymorphisms (SNPs) and release in public databases. Baseline: 2.4 million SNPs in database	NIH / International HapMap Project

In addition to the HapMap, the Biodefense Research program conducts research for developing and testing vaccines, therapeutics, and prevention strategies so that America will be better prepared should another biological attack occur in the U.S. The Biodefense Research program-related goal shown in the table below is another representative trans-NIH effort that contributes to the achievement of this HHS strategic goal.

	PERFORMANCE MEASURES	AGENCY / PROGRAM
4b	Performance Goal: By 2004, develop two new animal models to use in research on at least one agent of bioterror. FY 2004 Target: Expand by 25% the animal model resources available for use by the research community and for licensing products under the FDA Animal Efficacy Rule. Baseline: 8 animal models available	NIH / Biodefense Research Program

The HapMap project, spotlighted on the following page, aims to create a more detailed map of the human genome so that researchers can more effectively develop treatments for a variety of genetic conditions.

SPOTLIGHT: NATIONAL HUMAN GENOME RESEARCH INSTITUTE (NIH)

PERFORMANCE MEASURE

By 2005, create the next generation map of the human genome, a so-called haplotype map (HapMap), by identifying the patterns of genetic variation across all human chromosomes.

Baseline: 2.4 million SNPs in database.

RESULTS

FY 2003 Target: For existing blood samples from U.S. residents of Western and northern European ancestry, obtain additional consent from the donors for this new use and begin genotyping 300,000 SNPs, sites in the human genome where individuals differ by a single letter in those samples.

FY 2003 Actual: All needed consents obtained and genotyping performed on 132,000 SNPs.

FY 2004 Target:	FY 2004 Actual:
Collect samples from populations in Japan, China, and Nigeria; complete collection of additional 3 million SNPs and release in public databases.	Collection of samples from populations in China, Nigeria, and Japan has been completed. NIH collected and publicly released 7.8 million additional SNPs.
Target: 3 million SNPs	Actual: 7.8 million SNPs

Understanding how genetic variations are inherited in Deoxyribose Nucleic Acid (DNA) "blocks" or haplotypes can provide researchers with an essential tool to uncovering the hereditary factors of diseases that afflict millions of Americans. Sites in the genome where individuals differ in their DNA spelling by a single letter are called SNPs. Recent work has shown that about 10 million SNPs are common in human populations. SNPs are not inherited independently; rather, sets of adjacent SNPs are inherited in blocks. The specific pattern of particular SNP spellings in a block is called a haplotype. Although a region of DNA may contain many SNPs, it takes only a few SNPs to uniquely identify or "tag" each of the haplotypes in the region. This presents the possibility of a major shortcut in identifying hereditary factors in disease. Instead of testing 10 million SNPs, a rigorously chosen subset of approximately 400,000 SNPs could provide the essential information.

Most common haplotypes occur in all human populations, although their frequencies may vary considerably. Initial studies also indicate that the boundaries between the blocks are remarkably similar among populations in Europe, Asia, and Africa. These data indicate that a human HapMap built with samples from these three geographic areas would apply to most populations in the world, although additional testing of this conclusion is needed.

NIH has taken a leadership role in the development of the HapMap, a catalog of the haplotype blocks and the SNPs that tag them. The HapMap is a tool that researchers can use to find the genes and variants that contribute to many diseases or disease risk. In addition, the HapMap will be a powerful resource for studying the genetic factors contributing to variation in individual response to disease once it does occur, as well as to drugs and vaccines. As the numbers of identified SNPs increase, they will be catalogued and made available to the research community in order to enhance the capacity and productivity of scientists studying the genetic basis of disease.

NIH met and greatly exceeded the target to collect and publicly release 3 million additional SNPs. Collection of samples from populations in China, Nigeria, and Japan has been completed.

The consortium had originally planned to identify an additional 3 million new SNPs to fill in areas where the current density of SNPs in public databases is not sufficient, but due to advances in technology the project has already identified a total of 7.8 million new SNPs. The consortium is collecting samples and consent from 270 individuals from four populations (U.S. residents with ancestry from Western and Northern Europe, Yoruba in Nigeria, Chinese, and Japanese). The consortium is also developing scientific strategies to choose which SNPs to study, to assess the quality of the data, and to derive haplotypes from the SNP data.

Strategic Goal 5:

Improve the Quality of Health Care Services

Improving quality of life and health in the U.S. requires enhancements to human services and health care. Studies show that many patients die from medical errors, some services and procedures are used unnecessarily, and screening tests are sometimes misread. When considering and selecting health care options, many Americans do not use comparative information on the quality of health care plans, doctors, or hospitals to make their choices. This goal focuses HHS efforts on implementing programs designed to improve the quality of health care services for all Americans.

The following table summarizes key metrics used by the responsible HHS Agency to evaluate the success of these programs and progress towards achieving the strategic goal.

PERFORMANCE MEASURES		AGENCY / PROGRAM
5a	Expand implementation of MedSun to a network of 240 facilities.	FDA / Medical Devices and Radiological Health Program
5b1	Improve the quality and quantity of preventive care delivered in the clinical setting for the patient population. FY 2004 target: Increase continuing medical education activities by developing a train-the-trainer program for implementing a system to increase delivery of clinical preventive services.	AHRQ / Prevention Portfolio
5b2	Increase the number of partnerships that will adopt and promote evidence-based clinical prevention. [1] FY 2004 target: Produce fact sheets for adolescents, seniors, and children. Partner with appropriate professional societies and advocacy groups.	

[1] 5.b.2 is a new measure. The Prevention Portfolio revised its measures during FY 2004 to include this new outcome measure. The results will be reported in the FY 2006 performance budget submission to Congress.

HHS has implemented many successful programs in this area. Efforts are targeted at reducing medical errors, increasing the quality and quantity of preventive care, and improving consumer and patient protection. HHS develops and disseminates information of evidence-based practices, information systems and new technologies for the home and clinical setting, and improved reporting systems for medical errors and adverse events. The performance measures listed above are representative samples of the HHS' efforts.

Accomplishments in improving health care services by the FDA's Medical Devices and Radiological Health program are spotlighted on the following page.

SPOTLIGHT: MEDICAL DEVICES AND RADIOLOGICAL HEALTH PROGRAM (FDA)

PERFORMANCE MEASURE: Expand implementation of MedSun to a network of 240 facilities.			
	FY 2002	FY 2003	FY 2004
Target	Implement MedSun by recruiting a total of 80 facilities for the network.	Build a MedSun hospital network of 180 facilities.	Build a MedSun hospital network of 240 facilities
Actual	FDA recruited, trained, and had 80 facilities participating in the network.	FDA recruited, trained, and had 206 functioning facilities for the network.	FDA recruited, trained, and had 299 functioning facilities for the network.

The Medical Devices and Radiological Health program ensures the safety and effectiveness of medical devices and eliminates unnecessary human exposure to man-made radiation from medical, occupational, and consumer products. FDA is concerned about long-term safety, performance in community practice, change in use setting, rare or unexpected events, and rates of anticipated adverse events, user error, and off-label use of medical devices. FDA uses a postmarket reporting system on serious adverse events that forms the basis for its public health actions, which include communicating risks to users and issuing product recalls.

The FDA Modernization Act mandates that FDA replace universal user facility reporting with the Medical Product Surveillance Network (MedSun). MedSun constitutes a representative profile of user reports. When fully implemented, MedSun will serve as an advance warning system for device problems, a laboratory for research, and a two-way communication channel between FDA and the user-facility community that will improve patient safety and offer feedback to manufacturers to improve device design. MedSun will also improve FDA decision making about device problems by generating more useful and diverse reports from trained, engaged reporters. Reports on "close calls" will allow FDA to evaluate a device issue before patient injury occurs. Better information will allow timelier signal detection and will enhance FDA's ability to analyze and react to problems. A key component of MedSun is to offer easily accessible information related to safe device use. MedSun participants will receive a continuous stream of feedback including newsletters, educational materials, publications, and other information.

The FY 2004 performance target was to expand the MedSun network to 240 facilities. FDA exceeded this performance target. FDA recruited, trained, and had 299 facilities functioning. Of the 299 facilities, 257 were hospitals with over 100 beds, 22 were other facilities, and 20 were nursing homes.

Strategic Goal 6:

Improve the Economic and Social Well-being of Individuals, Families, and Communities, Especially Those Most in Need

While substantial progress occurred in the past several years to reduce poverty, evidence supports a continued focus on helping those in need. This goal's focus is to promote and support interventions that help low-income families, children, the elderly, persons with disabilities, and distressed communities improve their economic and social well-being.

The following table summarizes key metrics used by the responsible HHS Agency to evaluate the success of its programs and progress towards achieving the strategic goal.

PERFORMANCE MEASURES		AGENCY / PROGRAM
6a	Percentage of those (current/former TANF recipients) employed in a quarter that were still employed one and two quarters later.	ACF / Temporary Assistance for Needy Families Program
6b	A significant percentage of Older Americans Act Title III service recipients live in rural areas.	AoA / Community-Based Services Program

Numerous programs are designed to meet this goal. For example, the TANF program promotes work and self-sufficiency through State- and Tribal-administered programs. The AoA Community-Based Services program ensures that local services are provided to seniors who are at risk of losing their independence. The two performance measures listed below are representative samples of HHS' efforts.

Accomplishments in AoA's Community-Based Services program are spotlighted on the following page.

SPOTLIGHT: COMMUNITY-BASED SERVICES (AoA)

PERFORMANCE MEASURE:	A significant percentage of Older Americans Act Title III service recipients live in rural areas.		
	FY 2002	FY 2003	FY 2004
Target	25% of AoA clients	34% of AoA clients	34% of AoA clients
Actual	28% of AoA clients	28% of AoA clients	Data available 09/2005

This program offers grants to States to provide comprehensive social and supportive services to vulnerable elderly individuals and their family caregivers. AoA and a network of State, Tribal, and local service entities provide essential home and community-based services across the country to help keep America's rapidly growing older population healthy, secure, and independent. Services provided to elders include meals, transportation, caregiver support, personal care, information and assistance, and health promotion.

To ensure that AoA programs serve populations in need, the Agency employs "targeting" measures, including one to increase the percentage of AoA clients who reside in rural areas. It is a challenge to provide needed home and community-based services in rural areas, where access is limited, distances are great, and service infrastructure is often insufficient.

AoA's goal for FY 2004 was to increase the percentage of its clients who reside in rural areas from 28 percent in FY 2003 to 34 percent. To determine whether this goal has been met, States will gather data from local communities and provide performance data for FY 2004 to AoA beginning in January 2005. Performance data demonstrate that AoA met its performance targets for FY 2002 and earlier.

In FY 2001, AoA initiated processes to improve the timeliness and quality of State Program Report data under the National Aging Program Information System. At that time, there was a 28-month lag between the end of the fiscal year and the date when data were available for analysis. To reduce this time lag, and to improve the quality of the data, AoA initiated a new central and regional office review process to foster the timely identification and correction of erroneous data. This verification and validation process has resulted in more intense data review at the Federal and State levels, and has reduced the data lag from 28 months to 10 months

In the FY 2005 budget process, this program received a rating of "Moderately Effective" during the PART review, a significant improvement over the FY 2004 assessment of "Results Not Demonstrated." AoA achieved the improved score through enhancements to its *Strategic Plan*, the development of efficiency measures, and the assignment of ambitious performance targets, such as the one for serving older persons in rural areas. AoA has continued to make improvements in response to the FY 2005 PART review by conducting detailed program evaluations for its program activities, and by better linking PART results and performance results to program budget requests.

Strategic Goal 7:

Improve the Stability and Healthy Development of Our Nation's Children and Youth

HHS focuses on nurturing the positive development of children and youth through programs that promote family formation, healthy marriages, and innovative ways to improve the school readiness of children. The Child Support Enforcement program ensures that support is available to children by locating parents, establishing paternity and support obligations, and increasing parental responsibility by promoting parental involvement in the lives of their children. Child Welfare programs, such as Foster Care and Adoption Incentives, provide safe and stable environments for vulnerable children. The Head Start program, intended primarily for preschoolers from low-income families, promotes school readiness by enhancing the social and cognitive development of children through educational, health, nutritional, social, and other services.

The following table summarizes key metrics used by HHS to evaluate the success of these programs and progress towards achieving the strategic goal.

PERFORMANCE MEASURES		AGENCY / PROGRAM
7a	Increase the Title IV-D collection rate (collections on current support/current support owed).	ACF / Child Support Enforcement
7b	Increase the number of adoptions toward achieving the goal of finalizing 327,000 adoptions between FY 2003 - FY 2008.	ACF / Child Welfare Programs
7c	Achieve goal of at least 80% of children completing the Head Start program rated by parent as being in excellent or very good health.	ACF / Head Start Program

Accomplishments in the ACF Child Welfare program designed to increase the number of adoptions are spotlighted on the following page.

SPOTLIGHT: CHILD WELFARE PROGRAMS (ACF)

PERFORMANCE MEASURE:	Increase the number of adoptions toward achieving the goal of finalizing 327,000 adoptions between FY 2003 - FY 2008.		
	FY 2002	FY 2003	FY 2004
Target	56,000 adoptions	58,500 adoptions	53,000 adoptions
Actual	53,000 adoptions [1]	49,000 adoptions [1]	Data available 09/2005

[1] Estimate based on data submitted by States as of 8/1/04.

The Child Welfare programs prevent maltreatment of children, create temporary placements for children who must be removed from their homes, and find permanent placements for those children who cannot be safely returned to their homes. Programs such as Foster Care, Adoption Assistance, and Adoption Incentive provide stable environments for those children who cannot remain safely in their homes, and assure children's safety and well-being while their parents attempt to resolve the difficulties that led to the out-of-home placement. When the family cannot be reunified, foster care provides a stable environment until the child can be placed permanently with an adoptive family or in a guardianship arrangement. Adoption assistance funds are available for a one-time payment for the costs of adopting a child as well as for monthly subsidies to adoptive families for care of the child. The Adoption Incentive program awards States for increasing adoptions from the public foster care system. ACF receives data from the States on adoptions and foster care through the Adoption and Foster Care Analysis and Reporting System.

ACF aims to finalize 327,000 adoptions from the public foster care system between FY 2003 and FY 2008. The Child Welfare programs finalized 53,000 adoptions in FY 2002, and 49,000 in FY 2003. The target for FY 2004 was to finalize 53,000 adoptions. This goal was 5,500 less than the FY 2003 goal. Between FY 1999 and FY 2002, ACF exceeded its cumulative goal of 194,000 adoptions. However, since 2000, the number of adoptions annually has flattened because there are 7 percent fewer children in the foster care system. In addition, targets did not take into account that the average age of children waiting for adoption would increase by almost 1 year during this same period, making it more challenging to find adoptive homes for the children.

The Foster Care program received a PART assessment during the FY 2004 budget process and was reassessed during the FY 2005 budget process, receiving a rating of "Adequate." OMB recommended that the program develop and introduce legislation that would permit the flexible use of funding so that dollars may be programmed to meet program goals, and include funding for independent evaluation.

Strategic Goal 8:

Achieve Excellence in Management Practices

To better accomplish all of HHS' goals and objectives the Department must improve its management practices. A central objective in achieving management excellence is to function as "One HHS" instead of acting as a collection of disparate Agencies. To this end, HHS is currently reforming Departmental management practices by consolidating activities and improving collaboration among Agencies in administering HHS programs. This goal focuses on reducing inefficiencies, fraud, and abuse, while maximizing the integrity and efficiencies in Departmental management practices. This goal and related activities also address ongoing efforts to reduce Medicare payment errors.

The following table summarizes key metrics used by the responsible HHS Agencies to evaluate the success of these programs and progress towards achieving the strategic goal.

PERFORMANCE MEASURES		AGENCY / PROGRAM
8a	Reduce the percentage of improper payments made under the Medicare Fee-for-Service Error Rate.	CMS / Medicare Integrity Program
8b	Returns per budget dollar invested in the OIG.	Office of Inspector General

HHS has implemented many successful programs to ensure that the Department is run productively and with integrity. For example, the Medicare Integrity program ensures the right Medicare amounts are paid to a legitimate provider for an eligible beneficiary. Similarly, the Office of Inspector General's (OIG's) Health Care Fraud and Abuse Control program conducts and supervises audits, inspections, and investigations of HHS programs, and provides guidance to the health care industry. The two performance measures listed above are representative samples of HHS' efforts.

Accomplishments in reducing the Medicare FFS error rate are spotlighted on the following page.

SPOTLIGHT: MEDICARE INTEGRITY PROGRAM (CMS)

PERFORMANCE MEASURE:	Reduce the percentage of improper payments made under the Medicare Fee-for-Service Error Rate.		
	FY 2002	FY 2003	FY 2004
Target	5%	5%	4.8%
Actual	6.3%	9.8% [1]	9.3% [2]

[1] The 9.8 percent shown is the unadjusted FY 2003 paid claims error rate.

[2] Per Improper Payments Information Act (IPIA) requirements, HHS began reporting on gross (under- and over-payments) results in FY 2004. The FY 2004 gross result was 10.1 percent.

CMS' program integrity efforts ensure the Medicare program pays the right amount to a legitimate provider for covered, reasonable, and necessary services that are administered to an eligible beneficiary. The program includes medical review and benefit integrity activities, provider education and training, Medicare Secondary Payer, and provider audits.

HHS reported an unadjusted paid claims error rate of 9.8 percent, or $19.6 billion in net improper payments ($21.5 billion gross), and an adjusted paid claims error rate of 5.8 percent, or $11.6 billion during FY 2003. During FY 2004, HHS worked to develop and implement appropriate corrective action. Further, for FY 2004, HHS determined a paid claims error rate of 10.1 percent, or $21.7 billion, in gross improper payments. To facilitate comparability with prior year results, HHS determined an FY 2004 net paid claims error rate of 9.3 percent.

The Medicare FFS improper payment estimate is derived from two programs: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring program. Each component represents about 50 percent of the erroneous payments. The CERT program calculates the error rate for Carriers, Durable Medical Equipment Regional Carriers, and non-Prospective Payment System inpatient hospital claims submitted to Fiscal Intermediaries.

HHS will continue to take corrective action to address causes related to the national Medicare FFS paid claim error rate and also continue to work toward reducing the Medicare FFS error rate. Further, HHS will determine a national Medicare FFS error rate in FY 2005.

The President's Management Agenda

The President's Management Agenda (PMA) articulates the Administration's strategy "for improving the management and performance of government." It consists of five government-wide initiatives (Strategic Management of Human Capital, Competitive Sourcing, Improved Financial Performance, Expanded Electronic Government, and Budget and Performance Integration) and several program-specific initiatives. HHS is a significant contributor to four of the program initiatives: Broadening Health Insurance Coverage and Faith-Based and Community Initiative; and two new initiatives for FY 2004: Real Property, and Research & Development (R&D) Investment Criteria. The following sections discuss HHS' efforts during FY 2004 to further the PMA and action plans to further promote progress in FY 2005.

What the PMA Scores Indicate		
Score	**Status**	**Progress**
G	Agency meets all of the Standards for Success.	Implementation is proceeding according to plans agreed upon with agencies.
Y	Agency has achieved intermediate levels of performance in all the criteria.	Some slippage or other issues requiring adjustment by the agency in order to achieve initiative objectives on a timely basis.
R	Agency has any one of a number of serious flaws.	Initiative in serious jeopardy. Unlikely to realize objectives absent significant management intervention.

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Government-wide Initiatives		
Human Capital	G	G
Competitive Sourcing	G	G
Improved Financial Performance	R	Y
Expanded Electronic Government	Y	G
Budget and Performance Integration	Y	G
Program Initiatives		
Broadening Health Insurance Coverage	Y	G
Faith-Based and Community Initiative	Y	G
Real Property	R	G
R&D Investment Criteria	G	G

Human Capital

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Human Capital	G	G

People are the single most significant resource available to leadership in the Department. The foundation of HHS and the key to its future success are its workforce, without whom the important mission-related work of the Department could not be accomplished. In a world of turbulent change, success depends on the workforce's ability to reach, learn, and adapt at rapid speed. The overall challenge for HHS is to develop and utilize its human capital in a strategic manner. To support the PMA, the Department is building a fully integrated human capital management approach that bridges the gap between where HHS is today and where HHS needs to be.

Specifically, HHS has developed and implemented strategic workforce plans to respond to and eliminate skills imbalances, and has sought to implement effective Department-wide recruitment and retention strategies. In addition, HHS has consolidated administrative functions to eliminate duplication and increase efficiency and effectiveness, delayered the organization to no more than four management layers to speed decision making, and deployed staff to mission-related functions to improve HHS as a citizen-centered Department.

Accomplishing these objectives has made HHS a better-managed organization that is leveraging its human capital, systematically measuring its performance, remaining focused on its mission, and anticipating and responding to future requirements. HHS has worked diligently to implement an effective Department-wide recruitment and retention plan. The Department has developed specific strategies for improving recruitment, retention, and succession planning that will help reduce skills gaps and attract and retain talent. Leadership recruitment and development programs are being institutionalized as part of HHS' human capital strategy.

FY 2004 Accomplishments:

- Established the HHS University, achieving economies of scale by providing a central focus for common needs training. The University coordinates centers of excellence for programmatic and scientific training across the Department.
- Recently completed workforce analyses have provided an empirical basis upon which the Department can build and implement strategic plans to address skills imbalances. Findings are linked to recruitment, retention, redeployment, career development, and succession planning programs.
- Consolidated 40 personnel offices scattered throughout HHS into four departmental human resources (HR) service sites to eliminate redundancy and duplication of effort, reduce HR staffing levels, and improve service.
- Completed a prototype for a web-based HR Accountability System that will help communicate objectives, manage behavior, and document performance within the HR function at the Department. By providing ready access to current performance data to all levels of the organization, it will facilitate translating Department strategy into operational objectives.
- In the last year HHS has adopted new automation technology to expedite production of vacancy announcements and classification of positions. Other programs have enabled automation of screening and rating applications, in-processing new hires, maintaining official personnel records, and workload tracking.
- The Emerging Leaders program has been a tremendous success, graduating its first class and hiring its third in July 2004.
- The Department's Senior Executive Service (SES) Candidate Development program provides an ongoing pool of future SES members to succeed over 100 executives across HHS. Twenty-five participants have developmental assignments within HHS, as well as training in core executive leadership skills. The announcement for the class of 2004 attracted over 350 qualified applicants.

FY 2005 Action Plan:

- Reduce skills imbalances through workforce reshaping, Emerging Leaders program, and developmental programs.
- Implement HR Accountability program in all HHS HR Centers.
- Implement additional HR automation programs, including workload tracking, electronic official personnel folders, and QuickClassification, a position description and job classification software package.
- Implement category rating, which provides authority to refer more than three candidates for selection. Utilize additional hiring flexibilities such as direct hire authority to improve recruiting program.

- Continue to improve workforce diversity through strategic recruiting efforts and gauge their effectiveness by evaluating results to determine the best sources of qualified applicants from targeted groups.

Competitive Sourcing

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Competitive Sourcing	G	G

In competitive sourcing, HHS is at the forefront of civilian agencies. For example, HHS was one of the first Federal agencies to develop and implement a long-range competitive sourcing plan, which is consistent with the revised Circular A-76, *Performance of Commercial Activities*. The Department also supports a fair and reasoned approach to competitive sourcing and encourages input from competitive sourcing programs across HHS Agencies.

FY 2004 Accomplishments:

- Since the start of the competitive sourcing initiative, the Department competitively sourced over 25 percent of its commercial activities. In FY 2004 alone, HHS completed six standard studies consisting of over 1,000 full-time equivalent employees (FTEs) in an average of 285 days and completed 33 streamlined studies consisting of 365 FTEs in an average of 69 days. While over 95 percent of the studies were retained in-house by government employees, opening these commercial activities to competition drove improvements such that HHS anticipates positive net savings and increased efficiency and performance.
- In FY 2003, "One HHS" conducted 121 competitions that included 2,764 FTEs. When fully implemented over the next several fiscal years, these competitions are expected to yield net savings of more than $250 million over a period of 5 years, for the greater benefit of HHS programs and the American taxpayer.

FY 2005 Action Plan:

- HHS has developed and will implement an FY 2005 competition plan. Based on the competitive sourcing knowledge that the Department has acquired in the past several years, the FY 2005 plan is designed to maximize efficiencies and savings. For example, the FY 2005 plan encourages the formation of Most Efficient Organizations for streamlined studies, which under the revised OMB Circular A-76 is only required for standard studies.
- HHS will demonstrate positive anticipated net savings and performance improvements from completed competitions. For a random sample of completed competitions, HHS will independently validate that the anticipated savings are realized.
- HHS will structure competitions to encourage increased private sector participation and regularly review work performed to determine whether performance standards are met and take corrective action when services provided are deficient.
- HHS will fully implement a Federal Activities Inventory Report (FAIR) Act database that will maintain the FY 2005 FAIR Act inventory data and beyond. This database system will be tailored to HHS specifications to enable the Department of run reports and queries, which will promote consistency in the FAIR Act inventories.

Improved Financial Performance

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Improved Financial Performance	R	Y

The goals and initiatives in HHS' *Financial Management Five-Year Plan* correlate with the key success elements articulated in the PMA. HHS' overarching financial management goals (1) provide decision makers with timely, accurate, and useful financial and program information; and (2) ensure that HHS resources are used appropriately, efficiently, and effectively. In correlation with the PMA, the plan's focal points include, but are not limited to: the results and timeliness of the annual financial statement audit, the continued development and implementation of a Unified Financial Management System (UFMS), and effectively managing improper payments across the Department.

Audit Results and Timeliness

HHS Audit Findings History: FYs 2000 - 2004					
	2000	2001	2002	2003	2004
Audit Opinion	Clean & Timely	Clean & Timely	Clean & Timely	Clean & Accelerated	Clean
Material Weaknesses per HHS Audit					
Medicare EDP Controls	X	X	X	X	X
Financial Reporting Systems and Processes	X	X	X	X	X

HHS has earned unqualified or "clean" opinions on its financial statement audits for the past 6 years. A clean audit opinion means that the Department's financial statements present its financial position fairly, in all material respects. During FY 2003 and early FY 2004, HHS successfully implemented an accelerated reporting and auditing pilot to test the Department's capacity to meet the accelerated reporting deadlines mandated for FY 2004. HHS was one of eight agencies, and one of only three Cabinet-level Departments to meet the accelerated reporting deadline of November 15, 45 days earlier than the previous reporting cycle. A key driver of this effort included the introduction of a new "top-down" audit approach, which consolidated several individual HHS Agency audits into a single review process. This new approach consolidated the number of individual audits being conducted throughout HHS without sacrificing the integrity of the overall audit process. However, despite recent successes, HHS continues to rely on antiquated, disparate systems to produce its financial statements and reports. This not only has contributed to two ongoing material weaknesses identified by HHS auditors (see table above and the audit report), but also makes for an inefficient process and complicates the identification and resolution of statement and audit issues. In response, HHS has spent the past several years developing and implementing a new, integrated financial system as described below.

Development and Implementation of a Unified Financial Management System

HHS currently is implementing its $700 million UFMS as part of Secretary Thompson's ""One HHS"" initiative. In June 2001, Secretary Thompson stated that "...the purpose of this endeavor is to achieve greater economies of scale, eliminate duplication, and provide better service delivery." Improved systems effectiveness and efficiency, enhanced management empowerment, improved compliance with legal and regulatory requirements, and strengthened internal controls are among the anticipated benefits of this new system scheduled for full implementation in FY 2007. HHS intends for full implementation of UFMS, as well as actions reflected in the corrective action plans, to resolve any remaining reportable conditions and nonconformances. Please refer to the "Systems, Controls, and Legal Compliance" discussion on page 57 for additional information about UFMS and the legacy systems currently in use.

One of the main components of UFMS is the Health Care Integrated General Ledger Accounting System (HIGLAS). CMS has initiated steps to implement an integrated standard general ledger system, know as HIGLAS, for the Medicare contractors, and its regional and central offices. HIGLAS will initially integrate the CMS' financial systems with the Medicare contractors' two existing shared claims processing systems. The CMS' current mainframe-based financial system will also be replaced by HIGLAS. Additionally, NIH is developing the NIH Business and Research Support System (NBRSS), which will migrate with UFMS by the end of FY 2006.

Managing Improper Payments

During FY 2004, HHS engaged in numerous activities to reduce improper payments in its programs. In its commitment to ensuring that taxpayers' dollars are appropriately spent, HHS has continued to work closely with its OIG and OMB to identify the best strategies for estimating, reducing and recovering improper payments in HHS programs. While HHS' extensively diverse funding portfolio and various program legislative barriers have presented challenges in identifying effective and cost efficient approaches for estimating improper payments, HHS achieved numerous accomplishments in its improper payment activities during FY 2004, including:

- Compiled a program inventory and completed program risk assessments for the purpose of identifying those programs which may be susceptible to significant improper payments as required by the Improper Payments Information Act of 2002 (IPIA). HHS expects that its risk assessment work for FY 2005 will be completed early in the year and that plans for measuring improper payments for high risk programs will be developed and implemented soon after.

- Implemented a recovery auditing program as required by Section 831 of the Defense Authorization Act of 2002. This included awarding a contract to a recovery auditing firm in June 2004. During the months of July – September 2004, the contractor worked with HHS payment offices to obtain electronic contract payment data files. The contractor will begin on-site recovery auditing in November of 2004. HHS expects that all payment offices will be engaged in on-site recovery auditing activities by the second quarter of FY 2005.

- Continued making progress in HHS' work on estimating payment errors for seven HHS programs identified in Section 57 of OMB Circular A-11, *Preparation, Submission and Execution of the Budget*: Medicare, Medicaid, SCHIP, Child Care, Head Start, Foster Care, and TANF. These are HHS' largest programs, accounting for about 89 percent of approximately $550 billion of FY 2004 outlays. HHS' accomplishments in these programs during FY 2004 include:

    - Medicare: HHS reported an unadjusted paid claims error rate of 9.8 percent, or $19.6 billion in net improper payments ($21.5 billion gross), and an adjusted paid claims error rate of 5.8 percent, or $11.6 billion last year. During FY 2004, HHS worked to develop and implement appropriate corrective action. Further, for FY 2004, HHS determined a paid claims error rate of 10.1 percent, or $21.7 billion, in gross improper payments.

    - Medicaid: HHS continued the Payment Accuracy Measurement (PAM) pilot. For the 12 States that participated in the second year of the pilot (FY 2003), payment accuracy estimates were determined. Eleven of the 12 States determined FFS payment accuracy

rates ranging from 81.4 percent to 99.7 percent, with 80 percent of these States having a payment accuracy rate over 95 percent; 5 of the 12 participating States determined Managed Care payment accuracy rates ranging from 97.5 percent to 100.0 percent, with 80 percent of the States having a payment accuracy rate over 99 percent. Twenty-seven States participated during FY 2004, the third year of the pilot.

- SCHIP: HHS expanded the Medicaid PAM pilot to include SCHIP. Fifteen States participated in the PAM pilot for SCHIP during FY 2004.

- Child Care: HHS initiated a pilot project with selected partner States to evaluate the feasibility of developing an efficient and cost-effective strategy for addressing improper payments in the Child Care program. This pilot will be useful in determining and implementing appropriate strategies.

- Head Start: HHS conducted reviews to determine the rate of improper payments associated with programs serving children from over income eligibility families beyond the 10 percent allowed. An error rate of 3.9 percent was computed for the Head Start program in FY 2004.

- Foster Care: HHS conducted eligibility reviews as required under program regulation. Further, HHS awarded a contract for expert support in determining a methodology for estimating improper payment errors consistent with the parameters set forth in OMB's IPIA guidance which will complement the current legislatively required review process.

- TANF: HHS engaged in various activities which were geared toward increasing program oversight and fiscal integrity in the TANF program. The results of these activities will be helpful to ACF in exploring possible methods for addressing payment errors and reducing the occurrence of improper payments in the TANF program.

- Implemented a new policy to hold managers accountable for identifying, reducing, and recovering improper payments. A new performance plan objective was established which requires that managers "identify and address weaknesses in grant system(s), procurement system(s) and finance offices to ensure recovery of improper payments and to reduce the number of improper payments by the Department."

- Participated in several work group initiatives under the joint Chief Financial Officers Council/President's Council on Integrity and Efficiency Erroneous and Improper Payments working group. The work groups have been exploring areas related to identifying a more coordinated and efficient Federal-wide approach for identifying and reducing improper payments.

HHS planned activities for these programs in FY 2005 include:

- Medicare Fee-For Service: HHS will continue to take corrective action to address causes related to the national Medicare FFS paid claim error rate and also continue to work toward reducing the error rate. Further, HHS will determine a national Medicare FFS error rate in FY 2005.

- Medicaid: HHS will report on the results of the PAM pilot for the 27 States that participated during FY 2004, the third and final year of the pilot. Further, HHS will work with a number of States to measure payment errors under a modified PAM pilot – the Payment Error Rate Measurement (PERM) pilot. HHS expects that the PERM program will be implemented in all States in FY 2006. ("Notice of Proposed Rulemaking" for implementation of the PERM program in FY 2006 was published in the *Federal Register* in the fourth quarter of 2004). In addition, the Health Care Fraud and Abuse Control account includes at least two projects (the hiring of 100 regional office positions to do prospective reviews of State Medicaid operations, and the Medicare/Medicaid data match program) designed to ferret out improper payments and identify areas in need of improved payment accuracy. OIG also continues to receive money from HCFAC to conduct audits on the Medicaid program. Finally, the Public Assistance Reporting Information System data match program managed by ACF primarily benefits the Medicaid program, and offers States numerous opportunities to improve their payment accuracy, especially in the Managed Care portion of their programs.

- SCHIP: HHS will report on estimated payment errors for the 15 States participating in the FY 2004 PAM pilot for SCHIP. These rates will be reported in the FY 2005 *PAR*. Also, the PERM discussed above will include payment error rate measurements for SCHIP.

- Child Care: HHS will continue working with the States in the Child Care pilot project that was initiated this year. Further, HHS will expand the pilot project to include preparing a plan for measuring payment errors.

- Foster Care: HHS will work with a contractor to identify the best approach for using the regulatory review process for determining a national Foster Care payment error rate. HHS plans to have identified a methodology for establishing and reporting on a Foster Care payment error rate in FY 2005.

- Head Start: HHS will take appropriate corrective action to address the causes of the 3.9 percent payment error rate reported this year. Further, HHS will determine a payment error rate for FY 2005.

- TANF: HHS will implement a plan to increase program oversight and fiscal integrity in the TANF program and act upon other opportunities to address improper payments in the TANF program as they surface. Further, HHS will continue exploring possible methods for addressing payment errors and reducing the occurrence of improper payments in the TANF program.

- IPIA Program Risk Assessments: HHS is working toward having many of its FY 2005 program risk assessments completed by the end of the first quarter; and will also be working to have plans in place for estimating payment errors for most of the programs determined to be high risk by the end of the second quarter.

- Recovery Auditing: HHS will begin on-site recovery auditing activities in all five contract payment offices by the second quarter of FY 2005. As improper payments are identified during FY 2005, HHS will work to determine causes and formulate necessary corrective action strategies. Also, HHS will use experiences in this first year of recovery auditing to improve on its recovery auditing strategies going forward.

More detailed information on the FY 2004 accomplishments and planned FY 2005 activities can be found in Appendix C.

Other Initiatives

During FY 2004, OMB began emphasizing the generation and use of financial and performance information for routine or "day-to-day" management decisions as a key component of PMA success. In response, HHS initiated a Department-wide study of the extent to which HHS Agencies produce and use this information for program and Agency management, and to identify opportunities for improved integration of financial and performance information. This is a significant undertaking, given the size, scope, and breadth of HHS activities across several Agencies.

FY 2004 Accomplishments:

- Streamlined and accelerated the annual financial reporting process making financial information more useful in decision making by shortening the time for providing financial information from 4 months to 45 days after the fiscal yearend.
- Added a quarterly financial reporting cycle to provide more timely information and to facilitate the annual reporting cycle.
- Initiated an HHS-wide analysis to identify the extent to which financial and performance information currently is being used to support routine or "day-to-day" management decisions. This analysis is intended ultimately to help identify core mission business functions within HHS Agencies and across the Department and to improve the utility and use of routine financial and performance information to support program and management decision making.
- Began a phased-in implementation plan for UFMS throughout HHS, beginning with NIH in FY 2004, to culminate with IHS and the final phase of CMS contractors in FY 2007.
- Initiated a study to consolidate resources performing similar activities across the Department to facilitate enhanced service delivery for core financial processes.
- Developed and implemented internal PMA scorecard to communicate to HHS employees' their responsibilities and achievements under the PMA.
- Awarded a contract for recovery auditing services.
- Developed and began implementing a project plan to comply with the IPIA.

FY 2005 Action Plan:

- Submit FY 2004 PAR by November 15, 2004.
- Continue progress in UFMS development and implementation:
  - Go live with two components of the UFMS implementation: CDC and FDA.
  - CDC and FDA: October 2004 - Will deploy General Ledger and the Accounting for Pay System.
  - Grants Processing will be added in the first quarter for CDC.

- CDC and FDA: April 2005 – Will deploy remaining components of the JFMIP Core Financial Management functionality.
- Finalize "day-to-day" study and implement improved reporting formats where warranted.
- The Department will continue working on the Shared Services effort.
- HHS will continue planning on the development of the Department-wide Enterprise Data Warehouse effort.
- HHS will continue to participate in the OMB Lines of Business project.
- HIGLAS will transition to some Medicare contractors.
- HHS will formally establish an Administrative Systems work group to ensure the Department manages its financial and mixed-financial systems projects.

Expanded Electronic Government

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Expanded Electronic Government	Y	G

HHS has made significant progress in expanding the use of electronic government (e-Gov) to conduct Departmental business and to serve citizens more effectively and efficiently. HHS has been a leader, a participant, and contributor in all of the PMA's e-Gov portfolios, as well as the crosscutting E-Authentication initiative, and is a strong contributor to the Lines of Business task forces for Financial, Grants, and Federal Health Architecture. HHS' strategic planning and performance management efforts have aligned all major IT projects with HHS IT strategic planning goals and objectives and those, in turn, are aligned with the Departmental goals and objectives.

The Department has made great strides in its HHS Enterprise Architecture program that will ensure the integration of e-Gov and HHS enterprise-wide initiatives as the Department pursues its architecture-based, modern IT delivery system. HHS has implemented a portfolio management tool that will ensure that the Department develops strong business cases and applies effective IT capital planning and control over IT investments.

FY 2004 Accomplishments:

- The Grants.gov (formerly known as e-Grants) program met all milestones related to the development and deployment of the Grants.gov *Find* and *Apply* mechanisms. Currently, all 26 grant-making agencies are posting funding opportunities on the Grants.gov *Find* mechanism.
- HHS continues to lead the Federal Health Architecture that envisions an information-driven partnership among educational, private, and public agencies, as well as citizens through an online public health network. The Consolidated Health Informatics initiative has been merged under the Federal Health Architecture operational umbrella and will be leveraged to address future issues of data and vocabulary standards within the context of the architectural segments being reviewed.
- Under the "Secure One HHS"" IT Security program, HHS has certified and accredited 90 percent of its IT systems and achieved the goal that 100 percent of HHS employees have received annual security awareness training. HHS drafted and circulated for comment the HHS *Information Security Program Policy* and the HHS *Information Security Program Handbook*.
- HHS developed and published an Enterprise Architecture linking performance to strategic and capital planning and budget processes.

FY 2005 Action Plan:

- Under the "Secure One HHS"" IT Security program, HHS plans to have 100 percent of its IT systems certified and accredited. In addition, HHS will strengthen the Federal Information Security Management Act plan of action and milestone process within each Agency to the point that the OIG judges it highly effective and aligned with the "Secure One HHS"" program. HHS will also ensure that 100 percent of HHS employees have received annual security awareness training.
- Grants.gov will continue its efforts to establish system-to-system interfaces with agencies, work with grant-making agencies to establish a schedule for placing application packages on Grants.gov's *Apply* mechanism, and increase agencies' adoption and utilization of the *Find* and *Apply* mechanisms.
- The Federal Health Architecture partners will continue to review health business processes and performance metrics broadly across the Federal Government in order to document processes, identify opportunities for collaboration, and ensure the effective exchange of health information across Federal departments. Partners' work groups will pursue their task to develop the architecture for health business processes based on level of interest and priority.
- HHS will continue to participate in the OMB Lines of Business project.
- HHS will execute its Earned Value Management Roadmap to achieve 100 percent American National Standards Institute-compliant earned value management for all major HHS developmental investments. Cost and schedule variances for 90 percent of these investments will be within 10 percent of the originally planned cost and schedule for each individual investment.

Budget and Performance Integration

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Budget and Performance Integration	Y	G

In FY 2004, HHS succeeded in improving its status to yellow for Budget and Performance Integration on OMB's PMA scorecard. HHS achieved this by implementing the outcomes and deliverables identified in OMB's Management Plan Agreement, which defines the milestones for successful achievement of budget and performance integration. HHS achieved a green progress rating for the second, third, and fourth quarter of this fiscal year. In FY 2004, HHS efforts focused on further integrating strategic goals and performance information into the Department's budget decision-making process, as well as taking active steps to improve program effectiveness; calculate full cost of programs; develop a methodology to calculate the marginal cost of measures; and promote accountability among program managers.

HHS continued using results of OMB's PART as a means of using program performance to inform budget decisions. Under the PART process, OMB evaluates a program's purpose and design, planning, management, and results and accountability to determine its overall effectiveness. At HHS, program managers use the PART to justify funding requests and legislative actions and to make program improvements. For example, as a direct result of PART recommendations, ACF plans to conduct national evaluations of major grant programs such as the Low Income Home Energy Assistance program. In addition, ACF's PART recommendations resulted in proposed legislation to better integrate Head Start, Child Care, and State-operated preschool programs. Section II of this report, *Program Performance by HHS Strategic Goal*, contains additional information on the PART.

FY 2004 Accomplishments:

- Sponsored a budget and performance conference for representatives from all HHS Agencies to share information and open a dialogue on budget and performance integration within the Department.
- Created the outline for the FY 2006 integrated performance budget by forming a design team that included a budget and a performance representative from every HHS Agency.
- Developed the FY 2006 budget that integrates performance and budget information at the HHS Agency and Department levels and provides full cost information for performance program areas.
- Submitted a methodology for calculating marginal costs for selected programs at FDA and CDC.
- Participated in OMB's PART process for the FY 2006 budget cycle. HHS completed 22 PART assessments for FY 2006, for a total of 65 assessed programs from FYs 2004-2006 representing well over 60 percent of the total HHS budget.
- Implemented a process for tracking and following up on PART recommendations.
- Reinforced efforts to link strategic planning goals with budget and performance decision making through the Secretary's Budget Council, which conducts the summer budget review process, by including performance and PART information along with budget materials for the Secretary's Budget Council meetings.

FY 2005 Action Plan:

- Refine and improve the integrated performance budget for FYs 2006 and 2007.
- Ensure that senior managers continue to meet and examine reports that integrate financial and performance information.
- Continue to implement PART recommendations.
- Strengthen and improve the measures used to track program performance.
- Continue to report the full cost of achieving performance goals accurately in budget and performance documents.
- Expand the use of marginal cost.
- Continue to ensure that budget decisions are informed by performance information.

Broadening Health Insurance Coverage

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Broadening Health Insurance Coverage	**Y**	**G**

The Medicaid program provides a lifeline to millions of low-income Americans who otherwise would lack health insurance coverage. However, many Americans still lack either private or public insurance coverage. Through a variety of initiatives, and in partnership with the Nation's governors, the Administration has made significant strides in addressing access to coverage for uninsured Americans.

Since 2002, when CMS first announced the HIFA demonstration initiative, a new approach to demonstrations in Medicaid and SCHIP, the Administration has encouraged new comprehensive State approaches to increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. HIFA puts a particular emphasis on broad Statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to

populations with incomes below 200 percent of the Federal poverty level. By supporting private coverage options in the States, the Administration has sought to promote new health care coverage without encouraging a "one-size-fits-all" approach. In addition to HIFA, CMS has approved broad-based section 1115 demonstrations in States such as Utah that expanded coverage to previously uninsured individuals.

Many uninsured women need treatment for breast and cervical cancer, and CMS has been working to ensure that as many States as possible take advantage of the opportunity for enhanced Federal funding under the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA). BCCPTA gave States enhanced Federal matching funds to provide Medicaid eligibility to a new group of women previously not Medicaid-eligible. The new option allows States to provide full Medicaid benefits to uninsured women under age 65 who are identified through the CDC's National Breast and Cervical Cancer Early Detection program, are in need of treatment for breast or cervical cancer, including pre-cancerous conditions, and are not otherwise eligible for Medicaid. This program, effective October 1, 2000, also allows States to extend presumptive eligibility to applicants to ensure that needed treatment begins as early as possible and that life-saving interventions may be made in a timely fashion.

Access to health care coverage is also a crucial factor in allowing Americans with disabilities realize their fullest employment potential. To ensure that the contributions of disabled individuals in the workforce are not overlooked and that the business community takes full advantage of disabled individuals' skills and talents, CMS has designed and implemented two groundbreaking employment initiatives mandated by the Ticket to Work and Work Incentives Act of 1999 (TWWIA): the Demonstration to Maintain Independence and the Medicaid Infrastructure Grants. These initiatives enable States to build supports for people with disabilities who would like to be employed.

FY 2004 Accomplishments:

- CMS estimates that HIFA demonstrations, if fully implemented, could result in as many as approximately 822,000 new enrollees, and non-HIFA demonstrations could result in as many as 681,000 new enrollees.
- Through the efforts of the Administration and the States, 49 States and the District of Columbia are now participating in the BCCPTA partnership with the CDC. Furthermore, nearly half of those participating States also have adopted a presumptive eligibility option. As of mid-2004, States reported having enrolled an additional 18,315 women in Medicaid since January 20, 2001.
- CMS has awarded grants to 45 States to develop an optional working disabled eligibility group (also known as "Medicaid buy-in"), increase the availability of Statewide personal assistance services, form linkages with other State and local agencies that provide employment-related supports, and create a seamless infrastructure that will maximize the employment potential of all people with disabilities. Since passage of the TWWIA legislation, the number of States with a Medicaid buy-in program has increased from 1 to 31 and enrollment has increased from 2,000 to over 68,000.

FY 2005 Action Plan:

- Continue to work with States to expand coverage through the use of the HIFA Demonstration initiative, Family Planning, and Independence Plus waivers.
- Develop guidance to implement the law to redistribute funding to States for SCHIP.
- Encourage States to apply for grants under the New Freedom initiative and to undertake efforts to maximize the employment potential for persons with disabilities through the development of

optional working disabled eligibility groups ("Medicaid buy-in"), and increasing the availability of Statewide personal assistance services.

Faith-Based and Community Initiative

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Faith-Based and Community Initiative	Y	G

The mission of the Center for Faith-Based and Community Initiatives (CFBCI) is to create an environment within HHS that welcomes the participation of faith-based and community organizations as valued and essential partners in assisting Americans in need. This mission is part of HHS' focus on improving human services for America's most needy populations. Through work completed in FY 2004, HHS has achieved a green progress rating for every quarter this fiscal year by making the following accomplishments in data collection, pilot projects, regulatory reform, and outreach/technical assistance.

FY 2004 Accomplishments:

- HHS awarded $568 million through 680 grants to faith-based and community organizations in 2003. This was a 19 percent increase in the dollars awarded that went to faith-based and community groups from 2002 and a 41 percent increase in number of grants awarded. Thirty-nine million dollars went to 129 novice grantees that had not previously received a Federal grant from HHS. This was an 8 percent increase from 2002 of dollars awarded to faith-based grantees and a 50 percent increase in number of grants awarded to novice grantees.
- HHS has begun to collect and meet the deadlines for the new data additions to the management agreement and provide that data to the White House and OMB.
- HHS CFBCI continues to publish success stories about the impact made on people's lives by HHS faith-based grantees. These stories are called "Snapshots of Compassion" and can be found on the HHS CFBCI website at www.hhs.gov/fbci.
- HHS continued its commitment to pilot projects with increases in funding to the Mentoring Children of Prisoners grant as well as the Compassion Capital Fund and receiving funding for the Access to Recovery program. These programs held training for applicants this past year, and HHS awarded grants in all three of these programs.
- HHS CFBCI published the HHS *Department-wide Religious Non-Discrimination* regulations for public comment and issued the final regulations. These regulations revise existing Department regulations to remove barriers to the participation of faith-based organizations in Department programs.
- SAMHSA and ACF published the final *Charitable Choice* regulations in the *Federal Register*. Implementation of these regulations continues and is being monitored by HHS CFBCI.
- The director of CFBCI held multiple outreach meetings throughout the country with potential grant applicants to provide them with an overview of the grant opportunities. This training utilized the *Deciphering Grant Opportunities* handbook developed by HHS CFBCI.
- SAMHSA and HRSA both held national conferences on the faith-based and community initiative as it dealt with organizations in health, substance abuse, and mental health.
- HHS CFBCI continues to improve the HHS CFBCI website by better organizing and naming topics. A yellow navigation bar better attracts and informs the public of new and urgent information. New

sections include “Snapshots of Compassion,” the “Grants Opportunities Notebook,” “Publications,” and “New Information.”
- ACF completed and printed the child care brochure for churches and religious organizations. A distribution schedule was used to provide the child care brochure to the faith-based community.

FY 2005 Action Plan:

- CFBCI will continue to collect data in cooperation with the HHS Agencies to evaluate the success of the initiatives. This includes the new requirements focusing on new data elements outlined by OMB and the White House.
- HHS CFBCI will continue its research agenda to properly evaluate the pilot projects of the initiative and provide interim data on these evaluations if they are not completed.
- HHS CFBCI will continue to facilitate the implementation of the regulatory changes that promote a level playing field for faith-based and community organizations. This effort will continue by providing training and information to Federal and State officials as well as individuals from faith-based and community organizations about the *Charitable Choice* regulations and the non-discrimination rule.
- HHS CFBCI will continue to provide outreach and technical assistance to faith-based and community groups through interaction with organizations via site visits, meetings, telephone conversations, and materials provided in print and electronically through the website.

Real Property

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
Real Property	R	G

Through the Real Property program initiative, HHS aims to establish an asset management plan, inventory, and performance measures that are consistent with Federal Real Property Council (FRPC) guidance. These tools, in turn, are expected to aid HHS in real property management and decision making. HHS also has identified efficient portfolio management, fostering mission success through occupant productivity and efficiency, and maintaining appropriate stewardship of real property as HHS-specific goals. To fulfill these goals, a comprehensive understanding of current HHS asset management procedures, use of Departmental work groups, identification of Federal/ private sector best practices, and contractor assistance are key components of the Department’s approach. The strategy to achieve these objectives is outlined below

FY 2004 Accomplishments

Real Property Asset Management Plan

- Awarded a contract for development of Real Property Asset Management Plan (RAMP).
- Conducted HHS Capital Investment Review Board for FY 2006 program and fully implemented the new Project Approval Policy and Project Approval Agreement for new constructions.
- Initiated update of HHS’ policy on use of Operating Funds for facilities construction and issued a review draft.

Automated Real Property Inventory

- Awarded a contract to develop real-time inventory of HHS owned, leased, or otherwise managed properties

Real Property Performance Measures

- Gathered current measures in use for deferred maintenance and facility condition across HHS Agencies and formulated a strategy for developing a standard Department-wide formula for these measures.

FY 2005 Action Plan

Real Property Asset Management Plan

- Identify which components of the FRPC asset management plan are addressed through existing HHS policies, manuals, or other documents. Develop a strategy to address components not fully incorporated within the Department's guiding principals through the issuance of new policies, procedures, and technology.
- Ensure Agency missions and strategic goals are adequately addressed in determining appropriate levels of investment by updating HHS policy on use of Operating Funds for facilities construction and issue draft for senior level review.
- Initiate Phase I of the periodic evaluation of real property assets by developing a tactical real property plan that identifies and addresses required new construction, leasing actions, and building renovations for HHS components in the Washington/Baltimore metropolitan area.
- Develop draft strategy for including RAMP components (i.e., identification of HHS housing requirements) in Agency budget submissions and issue FY 2007 facility program budget guidance based on approved strategy as part of the HHS facility capital planning and budgeting prioritization process.
- Initiate Phase II of asset evaluation process by developing a nationwide real property housing plan that addresses mission-dependant new construction, leasing and building renovations, including proposed Agency FY 2007 construction projects submitted to the HHS Capital Investment Review Board and requirements established during Phase I (i.e., development of the *Washington/Baltimore Metropolitan Real Property Housing Plan*).
- Complete draft RAMP that includes a real-time HHS real property inventory (see item below), FRPC performance measures (see second item below), and a 5-year portfolio management plan based on Agency submission of annual 5-year facility requirements plan as part of the FY budget submission process and the findings of Phase I and II of the *HHS Real Property Housing Plan* asset evaluation process that addressed mission dependent new construction, leasing, renovation, and disposal requirements.

Automated Real Property Inventory

- Determine appropriate data fields, with FRPC guidance, for HHS Automated Real Property Inventory System (ARPIS).

- Identify system requirements and initiate the development of interface requirements with the General Services Administration, based on approved FRPC guidance on required data fields; select required hardware and software; initiate data migration from current Agency databases; and develop draft phase-in procedures for an HHS implementation plan for review by Agency facility directors and system users.
- Determine training requirements, issue procedures guide, and conduct comprehensive training for staff on use of APRIS software.
- Fully implement APRIS, consistent with FRPC standards and data fields, and provide real property information to government-wide real property database.

Real Property Performance Measures

- Meet with Agency facility directors and discuss a strategy for the formation of Departmental work groups which will identify and submit a list of existing performance measures that address, most notably four key areas, as defined by the FRPC Performance Measures Committee: utilization, operational cost, facility condition, and mission dependency. Identify other performance measures from approved FRPC guidance that are required for appropriate stewardship of HHS facilities and implement a strategy using work groups composed of Agency senior officials to develop needed metrics for determining acceptable HHS-wide standards.
- Review Agency PART scores for facilities construction programs and identify performance measures in scoring as part of evaluation process.
- Establish senior-level Departmental work group to draft Departmental policies and required technical guidance to implement FRPC government-wide performance measures and specific HHS specific facility stewardship initiatives.

Research and Development Investment Criteria

PMA ELEMENT	Status (as of Sept 30, 2004)	Progress in Implementation
R&D Investment Criteria	G	G

HHS continues its commitment to ensuring that its investments in R&D are effective and yield new knowledge for the development of diagnostics, treatments, and preventive measures to improve health and quality of life for all Americans. Central to the development and implementation of objectives under the Department's Strategic Goal 4, "Enhance the capacity and productivity of the Nation's health science research enterprise," are the OMB R&D investment criteria: relevance, quality, and performance. These criteria are considered carefully as research goals and associated targets are developed, as management changes are considered, and as budget decisions are made by HHS and its Agencies.

The first criterion, relevance, is addressed in several ways as it relates to research. Primarily, research priorities are set by considering public health needs, as judged by the incidence, severity, and cost of specific disorders as a key factor in determining areas of research support. Incorporating the views of the public into the HHS Agencies' research agendas also ensures relevance. This occurs through meetings of advisory councils or boards that include representatives of the public as members, by publishing research plans for public comment, and by meeting with representatives of patient groups and presenting NIH research plans and seeking feedback. In addition, relevance is also considered when planning for activities that will occur after the research is completed. These activities, e.g., developing and disseminating educational materials or implementing public education campaigns based on results from NIH-funded

research, help to ensure that the results of research reach the hands of those who can put the information to practical use. Through these efforts, policy makers, consumers, patients, and providers of care are making better-informed health care decisions and are receiving higher quality care as a result of HHS-supported research.

Quality, the second criterion, is embodied by a commitment on the part of the HHS Agencies to support work of the highest scientific caliber. The HHS Agencies ensure quality through the peer review process for grants, and the principles guiding this review for scientific merit are contained in the Public Health Service's scientific peer review regulations. The initial step of the peer review process takes place in Scientific Review Groups or study sections, and the second level of peer review is carried out by the National Advisory Councils.

The third criterion, performance, is key to each and every R&D goal set by the Department. Once priorities are set, peer review occurs, and funding decisions are made, performance is monitored on a regular basis. For example, grantees must submit annual progress reports. This information is reviewed to assess their performance, and follow-up actions are taken when necessary. In addition, there are other oversight mechanisms for reviewing progress, such as site visits. Aside from project-specific reviews, there are state-of-the-science reviews, workshops, and other scientific meetings where knowledge in a particular area of research is reviewed, and progress and performance are assessed. The performance criteria are also executed through HHS efforts to accelerate research productivity. Because HHS cannot predict discoveries or anticipate the opportunities that fresh discoveries may produce, HHS supports research along a broad and expanding frontier. The overall performance of the research enterprise also requires that HHS support the human capital and material assets of science.

FY 2004 Accomplishments:

- The NIH Council of Public Representatives completed a report entitled, "Enhancing Public Input and Transparency in the National Institutes of Health Research Priority Setting Process."
- The NIH published its *Strategic Plan for Obesity Research* for public comment. http://www.obesityresearch.nih.gov/about/strategic-plan.htm.
- A major effort is underway to reorganize many of the Scientific Review Groups to keep pace with the ever-changing landscape of science, thus helping to ensure the quality of peer review. In FY 2004, the final phase of implementing that reorganization was begun and new study sections created within the reorganization framework began to meet. http://www.csr.nih.gov/review/reorgact.asp.
- NIH built upon a strong foundation of basic and clinical science to accelerate program research. For example, the time from identifying a disease, e.g., Influenza, to characterizing its cause, formerly took decades. But the time to identify HIV was only 3 years, and with SARS, NIH-funded scientists characterized the disease within 4 weeks. Similarly, with the development of treatments, it took 60 years from the discovery of the infectious agent in Tuberculosis to the first promising drug treatment; but for HIV, the initial treatments were introduced in 3 years; and with SARS, barely 1 year after characterizing the agent, there are already two candidate treatments in therapeutic trials.

FY 2005 Action Plan:

- The Council of Public Representatives will develop a framework for describing and identifying cues that affect public trust, for understanding the importance of building a reputation for trust from the

public perspective, and for uncovering factors which enhance the capacity for trust in research participation, thus helping to strengthen the relevance of clinical research to volunteer participants.

- NIH is committed to assessing study sections at regular intervals by distinguished site visitors using the working group process developed through the recent review group reorganization process and through "customer" surveys (targeting both program staff and applicants).
- NIH will work with HHS and OMB in implementing recommendations from the OMB PART process, where feasible, and in recommending changes to the PART instrument to ensure that there is flexibility in assessing programs with different organizational and budget structures.

Analysis of Financial Condition and Results of Operations

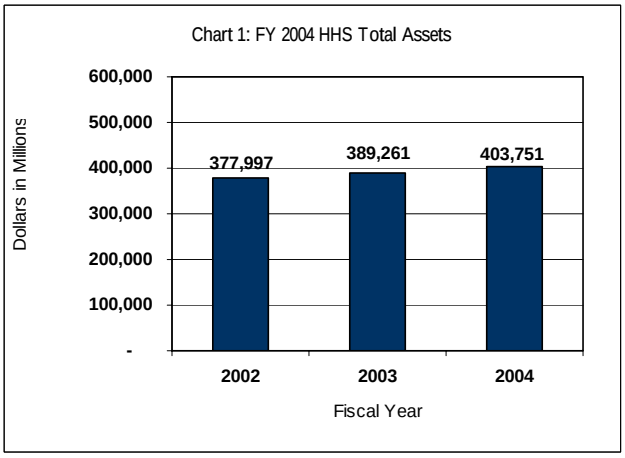
This section summarizes the significant changes in HHS financial condition during the past year. The following table provides an overview of HHS financial condition at the end of FY 2004 (dollars in millions).

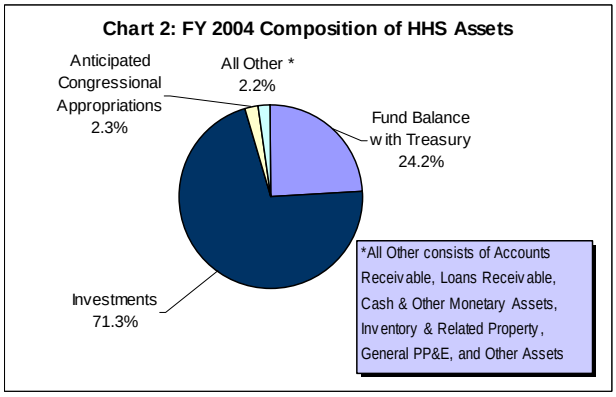
HHS Financial Condition	FY 2004	FY 2003 (Restated)	Increase (Decrease)	% Change
Total Assets	$ 403,751	$ 389,261	$ 14,490	3.7%
Total Liabilities	$ 66,818	$ 63,142	$ 3,676	5.8%
Net Position	$ 336,933	$ 326,119	$ 10,814	3.3%
Net Cost of Operations	$ 547,220	$ 510,366	$ 36,854	7.2%

Assets: What HHS Owns

Charts 1 and 2

HHS assets increased $14 billion or 3.7 percent to a total of $404 billion during FY 2004 as shown in Chart 1. Increases of $11 billion or 13.2 percent in fund balance with Treasury and $5.5 billion or 2.0 percent in Investments accounted for most of the change in total assets. The increase in fund balance with Treasury resulted primarily from increases to Medicare Supplementary Medical Insurance (SMI) and Hospital Insurance (HI). The increase to investments was primarily related to a net increase of $5.5 billion in the Medicare trust funds for SMI and HI. While SMI experienced a net decrease, HI experienced a larger net increase. As shown in Chart 2, HHS investments of $288 billion and its fund balance with Treasury of $98 billion together comprise 95.5 percent of HHS total assets. The fund balance with Treasury is HHS' "checkbook balance," or the aggregate amount of funds deposited in the Treasury available to make authorized expenditures and pay liabilities. At the end of FY 2004, approximately $286 billion or 99 percent of HHS investments were in U.S. Treasury securities to support the Medicare trust funds, which include HI





and the SMI trust funds. Established in 1965 as Title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people age 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. Medicare is a combination of three programs: HI, SMI, and Medicare Advantage. Since 1966, Medicare enrollment has increased from 19 million to approximately 42 million beneficiaries.

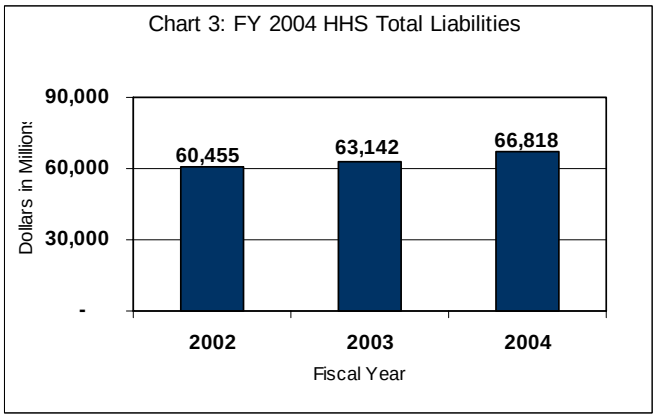
Hospital Insurance

HI or Medicare Part A, is usually provided automatically to people age 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities. As reported in the Required Supplementary Stewardship Information (RSSI) section of this report, HI trust fund assets steadily increase through 2009. At this point, expenditures start to exceed income including interest, thus drawing down assets until 2019 when they would be depleted. The shortfall between income and expenditures is due in part to the attainment of Medicare eligibility, starting in 2011, of those born during the 1946-1964 baby boom, and also due to health costs that are expected to increase faster than workers' earnings. Actual economic conditions, however, could delay (in the case of economic recovery) or accelerate this condition. Based on estimates from the Mid-Session Review of the FY 2005 President's budget, inpatient hospital spending accounted for 71 percent of HI benefit outlays. Managed Care spending comprised 13 percent of total HI outlays. During FY 2004, HI benefit outlays grew by 8.7 percent. The HI benefit outlays per enrollee are projected to increase by 6.8 percent to $4,040.

Supplementary Medical Insurance

SMI, or Medicare Part B and Medicare Part D, is available to nearly all people age 65 and over, the disabled, and people with end-stage renal disease requiring dialysis or kidney transplant who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, Medicare prescription drug discount card enrollment fees and prescription drug expenses for Transitional Assistance beneficiaries, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 95 percent of HI enrollees elect to enroll in SMI. Whereas HI is funded primarily by payroll taxes, SMI obtains its funding through monthly beneficiary premiums and income from the general fund of the U.S. Treasury – both of which are established annually to cover the following year's expenditures. Thus, the SMI trust fund is in financial balance every year, regardless of future economic and other conditions, due to its financing mechanism. Funds not currently needed to pay benefits and related expenses are held in the SMI trust fund, and invested in U.S. Treasury securities. Under the Trustees' intermediate set of assumptions, the HI trust fund will incur an actuarial deficit of more than $8.2 trillion over the 75-year projection period, as compared to more than $5.9 trillion in the 2003 financial report. In order to bring the HI trust fund into actuarial balance over the next 75 years, very substantial increases in revenues and/or reductions in benefits would be required. Since the SMI trust fund is in financial balance every year, there has been substantially less attention directed toward its financial status than to the HI trust fund – even though the SMI expenditures have increased faster than the HI expenditures in most years and are expected to continue to do so for a number of years in the future. Also based on estimates, during FY 2004, SMI benefit outlays grew by 9.8 percent. Physician services, the largest component of SMI, accounted for 39 percent of SMI benefit outlays. The SMI benefit outlays per enrollee are projected to increase 8.3 percent

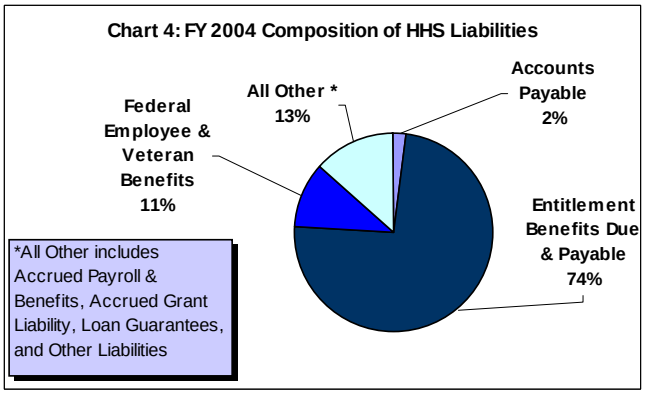
to $3,370. It is important to note that no liability has been recognized on HHS' balance sheet for future payments to be made to current and future program participants beyond the existing "incurred but not reported" Medicare claim amounts as of September 30, 2004. This is because Medicare is accounted for as a social insurance program rather than a pension program. A more detailed discussion of HHS' social insurance funds and other stewardship property and investments can be found in the Section III RSSI discussion of this report. A more detailed discussion of the Medicare Trust Fund can be found in RSSI and in the CMS financial report.



Liabilities: What HHS Owes

Charts 3 and 4

HHS liabilities increased $3.7billion or 5.8 percent to a total of $67 billion during FY 2004, as shown in Chart 3. This increase can be attributed primarily to a $1.1 billion or 2.3 percent increase to $49 billion in entitlement benefits due and payable (EBDP) and a $2.1 billion increase in other liabilities (refer to Footnote 7 in Section III of this report for discussion of the change to other liabilities). Entitlement benefits experienced a net increase due to the combination of HI, SMI, and Medicaid EBDP. Entitlement benefits account for nearly three-fourths of total liabilities, as shown in Chart 4. Entitlement benefits represent benefits due and payable to the public from the CMS insurance programs discussed above.



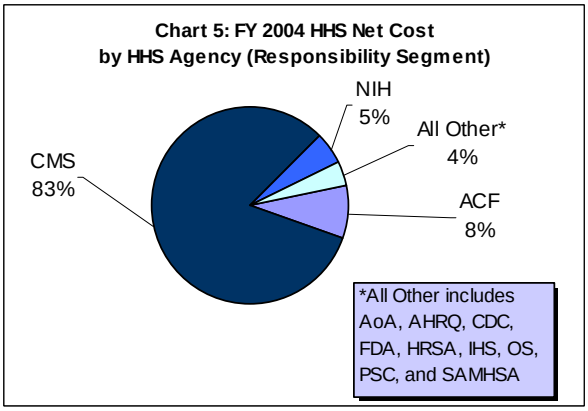
Statement of Changes in Net Position: Where HHS Stands

HHS' Net Position, which increased $11 billion or 3.3 percent to $337 billion at the end of FY 2004, consists of the cumulative net results of operations since inception, and unexpended appropriations, or those appropriations provided to HHS that remain unused at the end of the fiscal year.

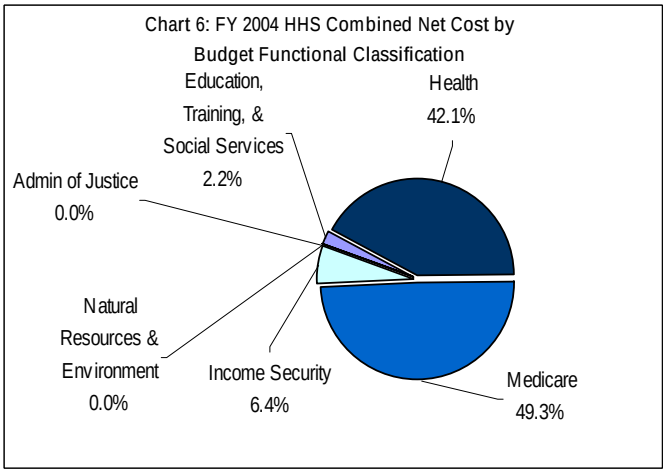
Net Cost - How HHS Spends

Charts 5 and 6

HHS incurred a total net cost for the year of $547 billion, which represents a $37 billion or 7.2 percent increase over FY 2003. This increase resulted primarily from largely normal program growth experienced by the Medicare HI and SMI, and Medicaid programs, as well as increased grant expenditures, contracted services, and payroll and benefit costs. The consolidated statement of net cost in Section III of this report presents HHS net operating costs by HHS Agency (which comprise of Departmental responsibility segments) while functional detail is



provided in the footnotes to the financial statements, also in Section III. As can be seen in Chart 5, CMS, ACF, and NIH account for a combined 96 percent of HHS' total net cost of operations, incurring net costs of $452 billion, $46 billion, and $26 billion, respectively. Chart 6 shows how HHS incurs net costs across its primary functions as defined in the budget. HHS' Medicare (49.3 percent); Health (42.1 percent); Income Security (6.4 percent); and Education, Training, and Social Services (2.2 percent) account for nearly all of HHS' net costs incurred during FY 2004. The percentages in Chart 6 reflect a proportional analysis of HHS' combined net costs (not accounting for intradepartmental costs and revenues). Intradepartmental net costs accounted for less than 0.1 percent of total combined net costs.



Budgetary Resources and Financing - Where the Money Comes From

During FY 2004, most of the funding to support net costs came from $700 billion in appropriations from Congress, as shown in HHS' Combined Statement of Budgetary Resources. This represents 96 percent of the gross budgetary resources available to HHS. This gross amount was offset by a pre-designated portion of funds that were either temporarily or permanently unavailable pursuant to specific legislation to derive a net funds available amount of $721 billion, an increase of 9.9 percent over FY 2003 levels. During FY 2004, HHS incurred obligations of $702 billion, an 8.2 percent increase over FY 2003, and made 7.5 percent more Net Outlays totaling $543 billion.

Cost vs. Outlays

The following concepts are critical for understanding the HHS financial history:

- Costs are typically reported in accounting reports, and are synonymous with expenses. These are the amounts recognized when services are rendered or goods are received. They are not necessarily linked to the outflow of cash in the form of check issuance, disbursements of cash, or electronic funds transfer.
- Costs incurred or expenses are netted against exchange or earned revenues to identify the net cost of programs.
- Outlays are payments to liquidate an obligation (other than the repayment of debt principal).
- Outlays generally are equal to cash disbursements, but also are recorded for cash-equivalent transactions.

Limitations of the Principal Financial Statements

The principal financial statements in Section III of this report have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990, as amended by the Reports Consolidation Act of 2000 (P.L. 106-531). While the statements have been prepared from the books and records of HHS in accordance with generally accepted accounting principles (GAAP) for federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records. The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity, and that the liabilities reported in the financial statements cannot be liquidated without legislation providing resources to do so.

Transfer of Department of Homeland Security Operations to HHS

The Homeland Security Act of 2002 resulted in changes to the structure of HHS in 2003. The Office of Emergency Preparedness, National Disaster Medical System, Metropolitan Medical Response System, and Strategic National Stockpile programs were transferred from HHS to the Department of Homeland Security,

and the Unaccompanied Alien Children program was transferred to HHS from the Immigration and Naturalization Service as of March 1, 2003. The Project BioShield Act of 2004 transferred back to HHS the Strategic National Stockpile program on August 13, 2004.

Grants Management

As the largest grant-awarding agency in the Federal Government, HHS plays a key role in Federal grants management. Through hundreds of assistance programs, HHS awards more than $240 billion in total Federal grant funding.

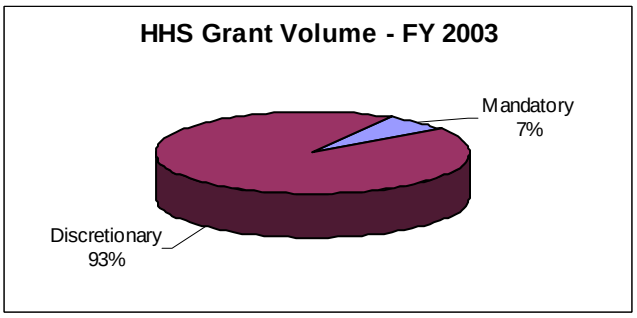
FY 2003 Grant Awards

HHS Agency/Office	Total Grants		Mandatory Grants		Discretionary Grants	
	#	$ (in millions)	#	$ (in millions)	#	$ (in millions)
ACF	7,331	$ 44,065	2,779	$ 36,896	4,552	$ 7,169
AHRQ	480	$ 149			480	$ 149
AOA	1,371	$ 1,284	1,088	$ 1,221	283	$ 63
CDC	3,027	$ 4,616	61	$ 130	2,966	$ 4,486
CMS	593	$ 164,866	354	$ 164,770	239	$ 96
FDA	121	$ 29			121	$ 29
HRSA	6,260	$ 5,780	171	$ 1,658	6,089	$ 4,122
IHS	605	$ 946	561	$ 934	44	$ 12
NIH	52,339	$ 19,785			52,339	$ 19,785
OS	432	$ 407			432	$ 407
SAMHSA	1,621	$ 2,839	232	$2,156	1,389	$683
TOTAL	74,180	$ 244,766	5,246	$ 207,765	68,934	$ 37,001
FY 2002	74,178	$ 221,653	4,699	$ 186,377	69,479	$ 35,276
FY 2001	69,085	$ 200,890	5,098	170,376	63,987	$ 30,514
FY 2000	64,433	$ 184,654	4,699	$ 160,008	59,734	$ 24,646

Grant awards provide financial support and assistance to accomplish a public purpose. Awards include grants and other agreements in the form of money, or property in lieu of money, to eligible recipients.

HHS awards most grant dollars in the form of mandatory grants. A mandatory grant is one that a Federal agency is required by statute to award if the recipients meet the eligibility and compliance requirements of the relevant statute and regulations. The remaining HHS grants are discretionary grants. Discretionary grants permit the Federal Government, according to specific legislation, to exercise judgment in selecting the project or proposal to be supported and selecting the recipient organization through a competitive process.

HHS grant program stewardship and oversight responsibilities involve a variety of ongoing administrative functions, including:

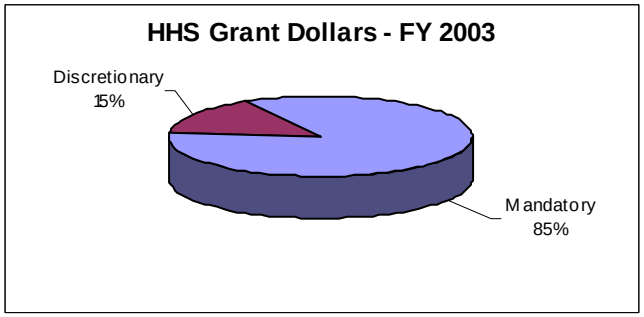


- Helping OMB revise key OMB Circulars pertinent to grants administration;
- Providing training and developing related guidance documents on these revised OMB Circulars;
- Conducting oversight through the "Balanced Scorecard Initiative;"
- Strengthening HHS indirect cost negotiation capabilities;
- Updating internal Departmental grants administrative procedures;
- Utilizing a Department-wide grants management information system to report on grant award data across all HHS grant programs;
- Reviewing Departmental program announcements; and
- Reviewing grant single audits by HHS OIG.

OMB designated HHS to be the lead agency to manage the Federal Grant Streamlining program, a government-wide effort required by the Federal Financial Assistance Management Improvement Act (Public

Law 106-107) of 1999. The program's goal is to streamline, simplify, and provide electronic options for the grants management processes employed by Federal agencies and improve the delivery of services to the public. Program initiatives encompass the entire grant life cycle and include: standardizing, simplifying, and streamlining the formats used to provide program synopses; announcing funding opportunities; and publishing the forms required to apply for and report on grant funds. HHS is also the lead agency for government-wide Grants.gov, a PMA e-Gov initiative. The HHS Grants.gov program office, in partnership with the 26 major grant-making agencies, is modifying and developing grants management practices and information systems that will allow current and prospective recipients of Federal grants to find, apply for, and manage grant funds online through a common website.

HHS also manages the Tracking Accountability in Government Grants System, which contains Department-wide grants award information. Access to this information is available to the public at http://taggs.hhs.gov. This site continues to provide public access to current policies, regulations, and other pertinent grants-related information.

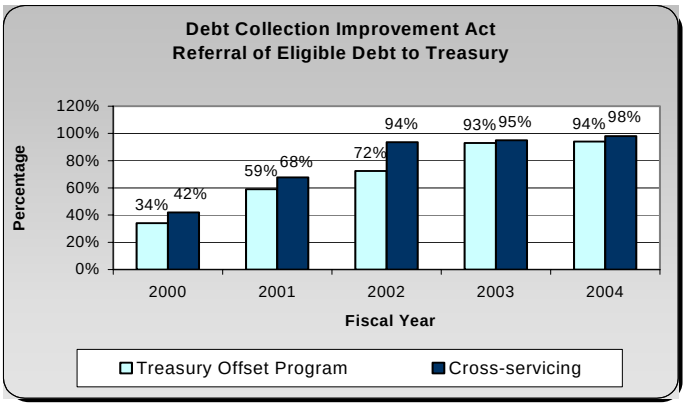


Highlights of FY 2003 grant awards (the most recent data available) include the following:

- Through hundreds of assistance programs, HHS awarded more than $240 billion in total Federal grant funding, consisting of more than $37 billion in discretionary awards and approximately $208 billion in mandatory awards.
- While CMS, which administers the Medicaid program, awarded less than 1 percent of the total number of grants, those grants accounted for two-thirds ($165 billion) of the total grant funds awarded.
- NIH awarded more than 52,000 grants or more than 70 percent of the total number of grants awarded, but only 8 percent of the total grant funds awarded.
- ACF, with more than 7,300 grants totaling $44 billion, awarded the second highest percentage of both total grant volume (10 percent) and funds (18 percent).

Debt Collection Improvement Act

HHS manages its delinquent debt pursuant to the Debt Collection Improvement Act (DCIA) of 1996. Although HHS refers delinquent debt to the Department of the Treasury (Treasury) for cross-servicing and offset, HHS has centralized the DCIA delinquent debt referral process by establishing the PSC as the Department's delinquent debt collection center. In addition, Treasury has granted a cross-servicing exemption for several types of program debts (e.g., Medicare Secondary Payer and various health professional loans).

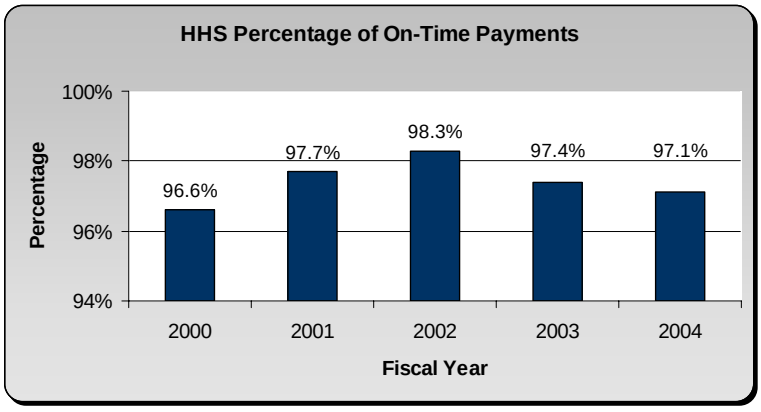


The PSC cross-services these debts and also refers them to the Treasury Offset program. According to the FY 2004 second quarter Treasury Report on Receivables, HHS and Treasury cooperative debt collection efforts have resulted in:

- HHS referral rates at the end of the third quarter FY 2004 as follows:
  - Treasury Offset program referrals increased to 95.4 percent of debt eligible for referral; and
  - Cross-serviced debt increased to 97.6 percent of debt eligible for referral.
- HHS collections exceeded $11.3 billion at the end of the third quarter FY 2004.

Prompt Payment Act

The Prompt Pay Act requires Federal agencies to make timely vendor payments and to pay interest penalties when payments are late. HHS increased its rate of on-time payments through FY 2002 when it reached a Department-wide record by making over 98 percent of payments on time. During the last 2 fiscal years, the on-time percentage decreased slightly but remained at 97 percent or higher.



Systems, Controls, and Legal Compliance

This section describes select systems that are critical to HHS Department-wide management, and discusses HHS' capacity to comply with the Federal laws and regulations that pertain to those systems and controls over the Department's resources. The systems discussion includes an overview of HHS' current key systems and details on the Department's future multi-million dollar implementation of UFMS, currently under development.

A cornerstone to improving HHS management practices is the Department's ability to maintain management systems, processes, and controls that ensure financial accountability; provide useful management information; and meet requirements of Federal laws, regulations, and guidance. HHS seeks to comply with a variety of Federal financial management systems requirements, including those articulated by the Chief Financial Officers Act, Federal Managers' Financial Integrity Act (FMFIA), Government Management Results Act, Federal Financial Management Improvement Act (FFMIA), JFMIP principles, OMB Circular A-127, *Financial Management Systems*, and the Clinger-Cohen Act of 1996. HHS' overall goals for its financial management systems focus on ensuring effective internal controls, timely and reliable financial and performance data for reporting, and system integration. The Department's immediate priorities are to address two material weaknesses (repeat conditions) identified in the CFO audit process: 1) financial systems and processes, and 2) Medicare Contractors electronic data processing (EDP) access controls. As in prior years, these findings are reported the Department's FMFIA Report as one combined FMFIA Section 4 material non-conformance. In addition, HHS is also reporting three new FMFIA material weaknesses, two of which were identified through the CFO audit -- Departmental Payroll System, and Departmental Financial Reporting, and one which was identified as a significant deficiency under the Federal Information Security Management Act (FISMA).

HHS Financial Management Systems

The table on the following page summarizes the existing key HHS systems that allow HHS Agencies to perform the majority of financial management business functions across the Department. HHS current financial systems environment consists of five core accounting systems including numerous feeder systems processing grants, travel, acquisitions, logistics, and other administrative systems.

2004 HHS FINANCIAL SYSTEMS ENVIRONMENT	
System Name	Description
PSC CORE	The PSC CORE accounting system records and reports the financial activity for 8 of the 12 HHS operating components. CORE is the nucleus of PSC's accounting operations and accepts and processes data supplied by feeder systems from the HHS Agencies as well as from the Payroll, Travel, and Payment Management Systems (PMS). The reliability of the information in CORE has been a major factor in achieving an unqualified "clean" opinion for all of the financial statement audits for the HHS Agencies serviced by PSC.
Payment Management System (PMS)	PSC's PMS is a centralized grants payment and cash management system serving 13 Federal agencies with 64 grant-awarding component offices and bureaus. PMS is operated by the HHS Division of Payment Management, Financial Management Service, PSC. The Chief Financial Officers Council has identified PMS as one of two civilian grant payment systems to serve all Federal civilian grant-awarding agencies. Of the two Council-designated systems, PMS is the only full service system available to the grant-awarding agencies. PMS is an automated system capable of receiving electronic or manual payment requests, editing them for accuracy and content, batching them for forwarding to the Federal Reserve Bank or U.S. Treasury for payment, and recording the transaction to the appropriate general ledger account(s). The legal or regulatory requirements met by this system include: the Cash Management Improvement Act; OMB Circulars A-102, *Grants and Cooperative Agreements With State and Local Governments*, and A-110, *Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals and Other Non-Profit Organizations*; DCIA; and 45 CFR Parts 74, 92, and 96 regulating HHS discretionary and block grants.
Accounting For Pay System (AFPS)	PSC's AFPS provides a systematic interface of payroll accounting information necessary to account for disbursements, expenditures, obligations, and accruals for personnel costs. This interface results in the production of accounting transactions and expenditure of reports to accomplish accounting requirements and payroll reconciliations. AFPS offers such features as labor distribution, common accounting number (CAN) adjustments, automated SF-224 report preparation, and pay and benefit history file.
Automated Financial Statement (AFS)	AFS is a web-based system used to compile the Department-wide financial statements.
Total Accounting On-Line Processing System (TOPS)	TOPS is the core financial system that supports most of the accounting functions at CDC.
General Ledger Accounting System (GLAS)	GLAS is the core financial application that supports most of the accounting functions at FDA.
NIH Business System (NBS)	NBS is the core financial system that supports most of the accounting functions at NIH.
Financial Accounting Control System (FACS)	FACS is the core accounting system used to compile accounting functions at CMS.
Payroll System	Payroll is the financial system that supports most of HHS' payroll functions.
Enterprise Human Resources and Payroll System (EHRP)	EHRP is the personnel system that supports HHS' personnel functions.

Transfer of HHS Payroll Functions to Defense Finance and Accounting Service

The Defense Finance and Accounting Service (DFAS) will begin to perform the payroll functions for HHS in FY 2005. Through the DFAS system, HHS employees will be able to view and print leave and earning statements in addition to viewing and printing employees' W-2's (Wage and Tax Statements).

HHS Financial Management System Weaknesses

Financial Management Systems Processes:

HHS continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. HHS' primary strategy to remedy this material weakness is the implementation of UFMS. Consistent with the vision of "One HHS," the Department is seeking to meet this goal by unifying and modernizing HHS financial management systems. UFMS is a business transformation effort designed to integrate Department-wide financial management systems and operations by aligning HHS' businesses with modern technological capabilities. Existing HHS financial management system configuration supports standard data elements and interface records. With UFMS, HHS will also standardize business processes for all core JFMIP functions including general ledger, accounts payable, accounts receivable, cost management, budget execution, and financial reporting.

General and Application Controls:

EDP weaknesses were identified for Medicare contractors in five primary types of controls: entitywide security programs, access controls (physical and logical), systems software, application software development and change controls, and service continuity. CMS continues to make progress in identifying and addressing weaknesses in its automated processing systems. Following the establishment of a baseline in FY 2002, CMS continues to assess the risks inherent in each area of vulnerability, assign priorities, and seek resources as necessary to correct known deficiencies. In addition, a critical goal of the HIGLAS investment is to integrate CMS accounting systems to produce audited financial statements. The first phase of HIGLAS is to develop the financial accounting and businesses related to Medicare contractor's claims payments. The next phase is to integrate all remaining Medicare Trust Funds, Medicaid, and administrative financial functionality. UFMS will contain a summary set of books, while HIGLAS would continue to process all of CMS core business program related activities and administrative processes.

The Department remains dedicated to ongoing performance improvement of its financial management environment. HHS, using the Secretary's "One HHS" vision as a guiding principle, is striving to establish an environment that uses efficient business processes, is supported by modern financial systems, and is consistent with Federal financial management requirements and best practices. The UFMS investment represents a substantial commitment toward establishing the target financial management environment across the Department. HHS will continue to monitor the progress and results of its financial management operations in the areas of financial accountability, usefulness of information, and compliance.

Department Payroll System

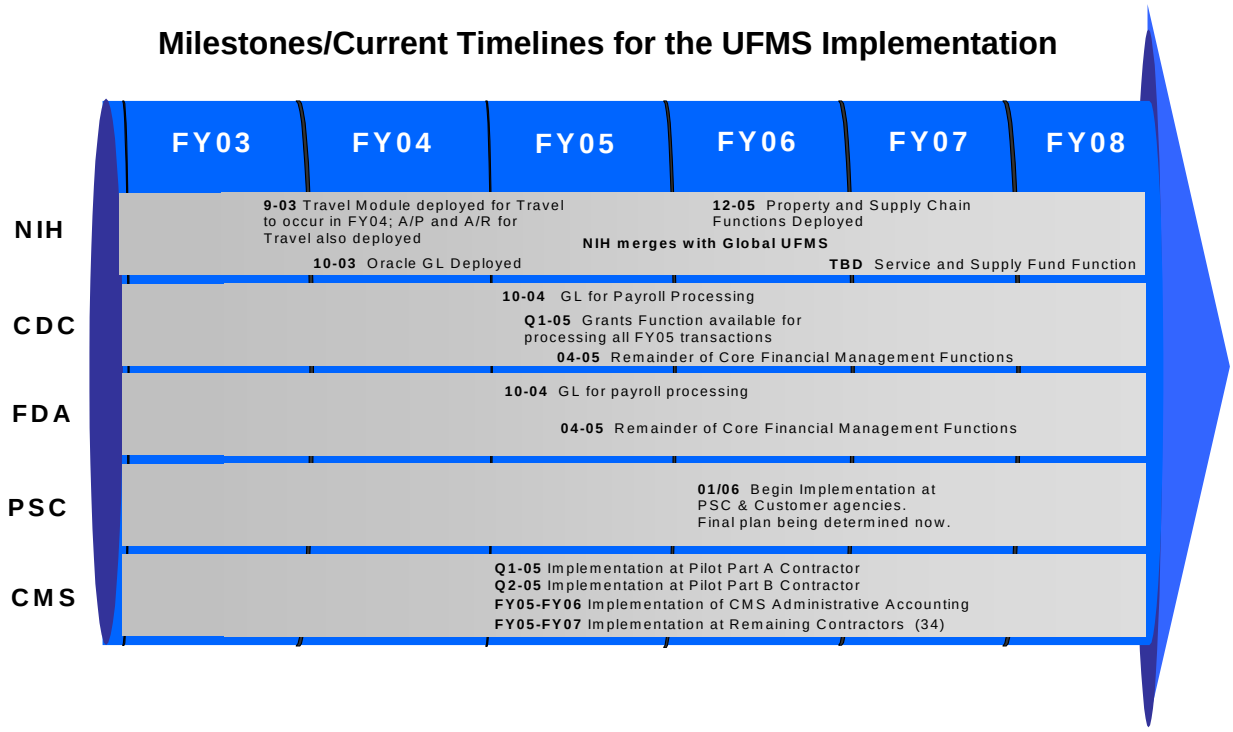
The Department also recognizes that its payroll systems controls need strengthening. The auditor's found that there are significant deficiencies in the Departmental Payroll System that could result in misstatements to payroll-account balances and the Commission Corp liability, improper payments, release of sensitive data, and reduced controls over safeguarding of assets. The Department recognizes that improvements can be made to the systems and processing activities that comprise the HR and payroll cycles. However, HHS has made significant changes to its human resources operation in response to the President's Management Agenda (PMA) including HR consolidation, implementing Department wide automated HR systems also referred to as electronic Official Personnel Files (e-OPF), and the transition to the Defense Finance and Accounting System (DFAS). The transition of payroll services to the Defense Finance and Accounting Service (DFAS), which is scheduled for March 2005. Additionally, the Electronic Official Personnel Folders (eOPF) project is scheduled for implementation from December 2004 - September 2005.

We believe our efforts in these areas will enhance our ability to have a solid payroll system while providing the Department with opportunities to comply with the FMFIA by the end of FY 2005. A corrective action plan is included in Appendix D, FMFIA Report (HHS-04-02).

UFMS Implementation

The UFMS investment will replace five legacy accounting systems (PSC's CORE Accounting System, CDC's TOPS, FDA's GLAS, NIH's CAS, and CMS' FACS) with a web-based, commercial, off-the-shelf product. Once fully implemented, UFMS will reduce the five legacy financial management systems to one modern accounting system, with two components: HIGLAS will support CMS and the Medicare contractors and the other will serve the rest of HHS. Upon completion, UFMS will be the largest civilian financial management system of the Federal Government.

The following illustration shows HHS' UFMS implementation milestones and current timelines.



UFMS will produce information that is timely, useful, and reliable and will support the integration of financial and performance information. Older mainframe systems such as PSC's CORE, FDA's GLAS, and CDC's TOPS cannot produce the information that program managers and decision makers need in a timely manner, nor can they provide the real-time processes needed to support effective e-Gov initiatives. By eliminating redundant and outdated financial systems and by standardizing business rules, data requirements, and accounting policies (particularly around the accounting classification structure), UFMS will reduce the extent of manual processes now involved in producing reports. This will increase the timeliness and accuracy of financial management information Department-wide, including HHS-level consolidated financial statements. Within HHS, UFMS establishes the foundation for full integration of financial and administrative systems and more robust cost management ability. UFMS also will strengthen the extent of internal financial management controls by providing automated funds control that will allow managers to accurately assess available program funds on a daily basis.

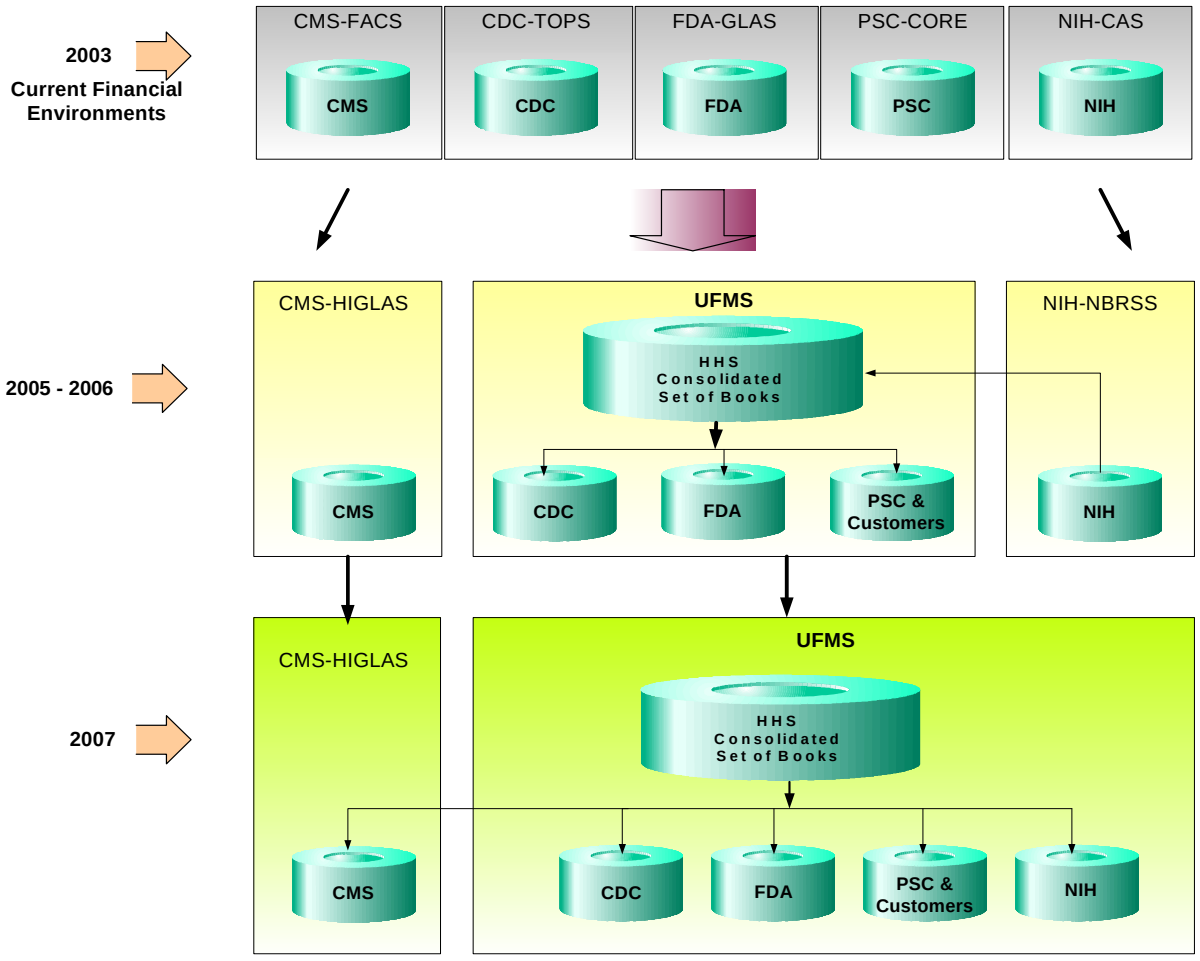
Finally, the Secretary's "One HHS" vision also will result in streamlining critical administrative systems that impact financial management functions, including grants and acquisition. In conjunction with these internal streamlining efforts, the Department will continue to ensure coordination with e-Gov initiatives efforts such as e-Travel, e-Payroll, e-Procurement, and Grants.gov.

HHS has ambitious implementation goals for UFMS. As currently structured, HHS is proceeding on three parallel tracks:

- Implementation activities for CDC, FDA, PSC, and their customers.
- NIH is proceeding with its modernization initiative, NBRSS. NBS will migrate with UFMS.
- UFMS is scheduled to be interfaced with CMS' HIGLAS by the end of FY 2007.

One major accomplishment necessary to enable the integration of these three tracks is to have a unified global design, including the recently completed budget and accounting classification structure. Parallel operations will run during October 2004 through April 2005 and open balances/documents will be transferred into UFMS. HHS anticipates deployment at the CDC and FDA in FY 2005. Implementation at HHS Agencies supported by PSC will be phased-in beginning in January 2006. The following illustration shows HHS' UFMS implementation strategy.

HHS Implementation Strategy



Key Targets and Performance:

The following chart contains key UFMS accomplishments for FY 2004.

Quarter	UFMS Accomplishments
1st Quarter (October 2003-December 2003)	• HIGLAS began Release 1 – Major Milestone 1. • NBS deployed General Ledger and Travel. • HHS identified a contractor for the Shared Service study. • Global conducted mini-Conference Room Pilots – a testing/training event that demonstrated structural financial scenarios.
2nd Quarter (January 2004 – March 2004)	• Conducted discussions with OMB regarding "accurate financial information on demand/used for day to day management." • HIGLAS rollout planned for non-pilot contractors. • FDA conducted Conference Room Pilots. • Global conducted Conference Room Pilot 2.
3rd Quarter (April 2004 – June 2004)	• HHS Shared Service study completed, financial shared services concept of operations developed. • NBS continued data conversion. • CDC conducted mock conversions 1-3. • CDC began end-user training.
4th Quarter (July 2004 – September 2004	• HIGLAS Release 1 – Major Milestone 2. (Development completed.) • CDC conducted integration testing. • PSC conducted Conference Room Pilot. • CDC conducted conversion tests. • CDC conducted system test.

More details about the UFMS initiative can be obtained through the UFMS website at www.hhs.gov/ufms.

Statement of Auditing Standards (SAS) 70 Systems Reviews

Independent examinations of HHS internal controls are completed annually under oversight of the HHS OIG. The service auditor's examination for FY 2004 was completed under the guidelines of the American Institute for Certified Public Accountants (AICPA) Statement of Auditing Standards (SAS) Number 70, *Service Organizations*. The annual examination is a "Type 2" report providing an opinion on the internal controls placed in operation and includes tests of operating effectiveness. The following summarizes HHS systems findings during the FY 2004 examinations.

PSC: Division of Financial Operations - CORE Accounting System and Feeder Systems and Information Technology Service Center

An independent examination was conducted of the HHS controls for the Information Technology Service Center (ITSC) and the Division of Financial Operations (DFO) general IT and application controls over the CORE accounting system and feeder systems (i.e., Accounting for Pay System, Travel Management System, Managing and Accounting Credit Card System (MACCS), Accounts Receivable System, and the Debt Management Collection System). In the examiner's opinion, the description of controls presents fairly, in all material respects, the relevant aspects of the DFO and ITSC controls that have been placed in operation as of June 30, 2004.

In the examiner's opinion, except for control objective "Controls provide reasonable assurance that an entity-wide program for security planning and management is established as the foundation of an entity's security control structure and a reflection of senior management's commitment to addressing security risks" that was not operating with sufficient effectiveness in the ITSC security program, the specific controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of July 1, 2003, to June 30, 2004.

PSC: Human Resources Service Personnel and Payroll Systems

An independent examination of HHS internal controls for the PSC examined the PSC general IT and application controls over the Human Resources Service personnel and payroll systems (i.e., Civilian Payroll System, EHRP, and the Commissioned Officer Personnel and Payroll System). In the examiner's opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of July 1, 2003, to June 30, 2004 except for as noted below:

- ITSC did not certify and accredit the local area network (LAN) supporting the Human Resources Service operations.
- Network equipment maintained by the ITSC that support the internal LAN-based resources operated by Commissioned Corps Support Branch were vulnerable to a known security vulnerability.
- Password controls over EHRP do not enforce password composition rules, default passwords are assigned upon initial use, and a password history is not maintained.
- An excessive number of EHRP users had been granted access to the Security Administrator role.
- Permissions in EHRP were not properly assigned to prevent one individual from initiating and approving a personnel transaction.
- Certain transactions in EHRP that are subject to manual user intervention may inadvertently not be included in the EHRP data file sent to the Civilian Payroll System on a nightly basis.
- Control weaknesses under authorization controls does not provide reasonable assurance that only authorized transactions are entered into and processed by EHRP.

PSC: Division of Payment Management

An independent examination was conducted of HHS internal controls for the Division of Payment Management. In the examiner's opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of July 1, 2003, to June 30, 2004. The controls identified were suitably designed to

provide reasonable assurance that the specified control objectives were achieved and all Division of Payment Management controls were complied with satisfactorily.

NIH: Center for Information Technology

An independent examination was conducted of HHS internal controls for the NIH's Center for Information Technology. In the examiner's opinion, except for procedures for "System Software Implementation and Maintenance for the Windows Environment," the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of July 1, 2003, to June 30, 2004.

Legal Compliance

FMFIA requires that agencies establish controls that reasonably ensure the integrity of Federal programs and the use of funds. FFMIA requires agencies to implement and maintain systems that comply with specific government-wide system parameters and policies. The Federal Information Security Management Act (FISMA) lays out a framework for annual information technology security reviews, reporting, and remediation planning to improve Federal agency internal controls over information resources and ensure compliance with laws and regulations regarding computer security. The following summarizes the FMFIA, FFMIA, and FISMA issues that remain outstanding at the end of FY 2004.

Federal Manager's Financial Integrity Act

At the end of FY 2004, the Secretary reported three new material weaknesses under Section 2 of the Act . The first is based on a finding of a Department-level significant deficiency under FISMA that is programmatic in nature in the Department's FISMA report to OMB. For the second material weakness the auditors found that there are significant deficiencies in the Departmental Payroll System that could result in misstatements to payroll-account balances and the Commission Corp liability, improper payments, release of sensitive data, and reduced controls over safeguarding of assets. The third new material weakness is in the area of departmental financial reporting. Specifically, the auditors found that the department lacks a coordinated process among cross-functional teams of finance, operations and legal personnel to monitor business activities to identify situations where accounting evaluation or decision-making may be necessary. Under Section 4 of the Act, HHS is reporting one material nonconformance at the Department-level. Further details are provided in the full FMFIA report in Appendix D.

Federal Financial Management Improvement Act

FFMIA mandates that agencies "…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." FFMIA also requires that remediation plans be developed for any entity that is unable to report substantial compliance with these requirements.

As of September 30, 2004, HHS is reporting three noncompliances with the requirements of FFMIA. Two of the three non-compliances are: 1) financial management systems and processes; and 2) general and application controls over Medicare financial management systems and other HHS Agency systems. Implementation of the UFMS, as well as other activities identified in the corrective active plan, will eliminate these material weaknesses. A third non-compliance with the FFMIA is due to the need to enhance internal controls in the Departmental Payroll System.

Federal Information Security Management Act

HHS' FY 2004 FISMA evaluation determined that the Department has a significant deficiency in its information systems security program related to contingency planning and disaster recovery. The evaluation identified weaknesses in these areas at 11 of 13 HHS Agencies. For six Agencies, this was a repeat finding from a previous FISMA evaluation.

Looking Ahead to 2005 – HHS Management Challenges and High-Risk Areas

The breadth of services that HHS delivers and the myriad support functions required to support them create a number of management challenges, which help set the course for HHS improvement efforts each year. The OIG identifies these challenges and tracks HHS' progress in resolving them. Pursuant to the Reports Consolidation Act of 2000, Appendix A addresses the challenges identified by the OIG, and management's responses to those challenges in detail. As shown in the accompanying chart, many of the initiatives discussed in this report, both under the auspices of the PMA and HHS' own strategic goals, address these challenges. It should be noted that because many of the PMA initiatives address, in great part, government-wide issues, there will not necessarily be a complete correlation between HHS' management challenges and each of the PMA initiatives. There is, however, a more direct relationship between the challenges identified and HHS' strategic goals. It is this relationship that articulates, in part, HHS' efforts to resolve these challenges. As such, through the Department's many initiatives, HHS continually strives to improve not only the quality of services it delivers to its "customers" and beneficiaries, but also to enhance management effectiveness and efficiency.

Crosswalk of HHS Challenges and Goals		
HHS Top Management Challenges	President's Management Agenda	HHS Strategic Goal Number
Implementation of the Medicare Modernization Act		3
Payment for Prescription Drugs		3
Bioterrorism Preparedness		2
Integrity of Medicare and Medicaid Payments	Improved Financial Performance	8
Nursing Facilities		3, 5
Grants Management	Improved Financial Performance; Expanded Electronic Government	8
Protection of Critical Systems and Infrastructure	Expanded Electronic Government	8

(This page intentionally left blank)