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The Honorable Richard K. Armey
Majority Leader
House of Representatives

The Honorable John Kasich
Chairman, Committee on the Budget
House of Representatives

The Honorable Dan Burton
Chairman, Committee on Government
Reform and Oversight
House of Representatives

The Honorable Bob Livingston
Chairman, Committee on Appropriations
House of Representatives

Subject: The Results Act: Observations on the Department of Health and Human Services' April 1997 Draft Strategic Plan

On June 12, 1997, you asked us to review the draft strategic plans submitted by the cabinet departments and selected major agencies for consultation with the Congress as required by the Government Performance and Results Act of 1993 (the Results Act). This letter reports on our review of the Department of Health and Human Services' (HHS) draft strategic plan.

Objectives, Scope, and Methodology

Our overall objective was to review and evaluate the latest available version of HHS' draft strategic plan, dated April 1997. As you requested, we (1) assessed the plan's response to the Results Act's six requirements and the strengths and weaknesses of the plan's elements; (2) assessed whether the plan covers the agency's key statutory authorities; (3) examined whether any agency programs, activities, or functions are crosscutting, that is, similar to or related to goals, activities, or functions of other agencies, and the extent to which the strategic plan reflects interagency coordination; (4) determined if the draft plan addresses major management problems; and (5) provided a preliminary assessment of the agency's capacity to provide reliable information about performance.

The focus of our review was HHS' April 1997 strategic plan; we did not examine any plans prepared by HHS' component agencies because HHS intends to submit only a Department-wide plan. As agreed, to review the plan, we relied on the Results Act, the Office of Management and Budget's (OMB) guidance on developing the plans (Circular A-11, Part 2), our May 1997 guidance for congressional review of the plans (GAO/GGD-10.1.16), our general knowledge of HHS' operations, and the many reports and testimonies on HHS and its programs that we have issued over the last several years. (See Related GAO Products at the end of this correspondence.) As you requested, we coordinated our work on HHS' key statutory authorities and HHS' capacity to provide reliable information with the Congressional Research Service and HHS' Office of Inspector General (OIG), respectively.

In passing the Results Act, the Congress anticipated that several planning cycles might be needed to perfect the process of developing a strategic plan and that the plan would be continually refined. Thus, our comments reflect a "snapshot" of the status of the plan at a particular point. We recognize that developing a strategic plan is a dynamic process and that HHS is continuing to work to revise the draft with input from OMB, congressional staff, and other stakeholders.

We did our work between June 16 and July 8, 1997, in accordance with generally accepted government auditing standards. We met with HHS officials on July 8 to discuss a draft of this correspondence; they also provided written comments, which are presented in enclosure II.

Background

The Results Act seeks to shift the focus of federal management and decision-making from staffing, activity levels, and tasks completed toward results. Under the Results Act, federal agencies must develop (1) strategic plans by September 30, 1997; (2) annual performance plans for fiscal year 1999 and beyond; and (3) annual performance reports beginning on March 31, 2000. The act states that agencies' strategic plans should cover at least 5 years[1] and that these plans should include, among other requirements, a set of strategic goals. Although it was expected to encourage agencies to focus their strategic goals on results, the act does not require that all of an agency's strategic goals be explicitly results oriented. The act does not require agencies to have final plans until

[1]OMB Circular A-11, Part 2, requires that strategic plans span a minimum 6-year period: the fiscal year it is submitted, and at least 5 years following that fiscal year.

September 30, 1997, so many of these plans will most likely be imperfect, reflecting their status as draft documents.

The sheer size and complexity of HHS' responsibilities create great challenges for complying with the requirements of the Results Act. HHS is one of the largest federal departments, the nation's largest health insurer, and the largest grant-making agency in the federal government. Its fiscal year 1996 outlays were $319.8 billion. The Department comprises several large agencies, each of which manages a number of programs with many parts. (See enc. I.) The size, range, and interrelatedness of HHS' activities and responsibilities make it especially important for HHS to use the framework of the Results Act to integrate program goals and activities at a departmental planning level; improve coordination and accountability among its own agencies; and work successfully with other federal agencies, state and local governments, and private-sector grantees.

HHS is familiar with the kind of results-oriented management promoted by the Results Act. HHS conducted two of the Results Act pilots designated by OMB: one in the Administration for Children and Families' (ACF) Office of Child Support Enforcement (OCSE) and the other in the Food and Drug Administration's (FDA) Prescription Drug User Fee Program.[2] The pilots helped OCSE and FDA identify and progress toward performance goals. In October 1996, we reported that OCSE's Results Act pilot had made progress in redirecting its management of the child support enforcement program toward results.[3] For example, OCSE approved national goals and objectives focused on key program outcomes such as increasing the number of paternities established, support orders obtained, and child support collections received. At the time of our review, OCSE and the states had begun to develop performance measures as statistical tools for measuring state progress toward meeting program goals.

A second HHS Results Act pilot involved the Prescription Drug User Fee Act of 1992 (PDUFA), which allows FDA to collect user fees from drug companies seeking approval to market drugs. PDUFA dedicated the revenues to expediting FDA's review of human drug applications and

[2]When it passed the Results Act, the Congress understood that most agencies would need to make fundamental management changes to implement this law properly and that these changes would not come quickly or easily. To facilitate this process, the act included a pilot phase during which federal agencies could gain experience in implementing key parts of the law to provide valuable lessons for the rest of the government. OMB designated about 70 pilot tests in 26 federal entities for performance planning and reporting.

[3]Child Support Enforcement: Reorienting Management Toward Achieving Better Program Results (GAO/HEHS/GGD-97-14, Oct. 25, 1996).

established time-specific performance goals to be achieved by the end of fiscal year 1997. To meet these objectives, FDA consulted with its stakeholders to determine appropriate performance indicators and target levels and developed output-oriented performance goals. In its Fourth Annual Performance Review, for fiscal year 1996, FDA reported that the PDUFA program had exceeded its performance goals, improving the speed and efficiency of the drug review process.

In addition, Healthy People 2000, the Public Health Service's (PHS) national public health initiative that seeks to improve the health of all Americans, is an example of a results-based HHS management effort. In consultation with HHS stakeholders, other government agencies, and the public health community, PHS developed a series of outcome-based public health goals and measures, with 300 disease prevention and health promotion objectives. In 1995, PHS reviewed the nation's progress in meeting these objectives and reported that progress had been made toward achieving half of the objectives; movement away from the target or no movement at all had occurred for 21 percent; and insufficient data existed to assess 29 percent.

Results in Brief

HHS' draft strategic plan is more a summary of current programs than a document projecting actions the Department might take in the next several years to achieve its six goals. Although a description of current programs is helpful, a strategic plan should allow the Congress and the American people to understand the direction in which HHS' programs will move. The plan in its draft form does not provide a useful basis for consultation with the Congress and others interested in the Department's future. Greater attention in the plan to the six critical elements in the Results Act would allow for more informed evaluation of the appropriateness of HHS' goals and objectives and the strategies for achieving them. HHS officials recognize that the plan is incomplete but felt that it was important to make available at least the framework for the plan in time to get comments from their many stakeholders. Officials said they have been working on the missing elements and expect to have them in place by September 30.

Specifically, while the plan's mission statement successfully captures the broad array of the Department's activities, many required elements of HHS' draft strategic plan are incomplete or missing. The draft plan identifies six overarching Department-wide goals, such as to improve the quality of health care, public health, and human services and to promote

self-sufficiency and parental responsibility. It also recognizes that many different departmental agencies, such as the Health Care Financing Administration (HCFA), the National Institutes of Health (NIH), and ACF, are responsible for achieving the goals. HHS has not, however, consistently identified strategies for achieving the goals or included measurable objectives indicating, for example, how to measure an increase in self-sufficiency. Nor did HHS adequately discuss how its component agencies, such as HCFA and the Health Resources and Services Administration, will coordinate their efforts to reach common goals.

Similarly, the draft plan does not sufficiently acknowledge the many other federal partners, like the Department of Education, that share responsibility with HHS for many of the same kinds of programs, such as education and training. Also missing are discussions of the considerable management challenges HHS faces in carrying out both its program responsibilities and the type of strategic planning and performance measurement the Results Act requires. In particular, the draft plan does not give enough weight to the role that state and local governments play in carrying out many of HHS' programs and the fact that these partners may lack the capacity to provide reliable and comparable information on achieving HHS' goals.

Draft Strategic Plan Omits Discussion of Key Elements Required by the Results Act

HHS' draft strategic plan does not adequately address five of the Results Act's six key elements. The six elements are (1) mission statement, (2) goals and objectives, (3) approaches to achieve goals and objectives, (4) relationship between long-term goals/objectives and annual performance goals, (5) key external factors beyond the agency's control, and (6) how program evaluations were used to establish/revise strategic goals. All of these elements are important for establishing a meaningful starting point and foundation for HHS' consultations with the Congress and stakeholders in defining the Department's aims, identifying the strategies it will use to achieve desired results, and then determining its success in meeting its goals and objectives. More completely addressing the six key elements of the Results Act is essential for HHS to move from a draft strategic plan that too often merely describes the Department's programs and processes to a tool useful for projecting organizational priorities and unifying the Department's staff in the pursuit of shared goals. Although HHS has developed a mission statement that successfully captures the broad array of the Department's activities related to the health and well-being of the nation as well as the Department's support for social- and

health-related research, discussion of the remaining five elements in its draft strategic plan is missing or incomplete.

Goals and Objectives Statement Is Incomplete

HHS has partially addressed the Results Act requirement to establish general goals and objectives in the agency's draft strategic plan. Although HHS has established six goals that are overarching for its operating divisions and staff offices, the Department needs to take further action in three areas to completely address the Results Act requirements for goals and objectives.

First, HHS states that these six goals relate to those activities that have priority over the next 6 years; they do not relate to every Department activity that contributes to the overall mission. The Results Act and OMB Circular A-11 require, however, that agency plans cover the Department's major functions and operations. The current HHS draft plan may be missing major functions and operations that are reflected in statute or are otherwise important to HHS' mission. Excluding some significant programs and activities obscures their relationship to the six departmental goals and the methods for ensuring the accountability of these efforts. The draft strategic plan, for example, makes no mention of HHS' responsibilities for certifying medical facilities, such as clinical laboratories and mammography providers. Furthermore, to achieve the objectives of the Government Management Reform Act of 1994 (GMRA), agencies must have implemented financial management systems that provide adequate safeguards and accountability. Despite numerous known financial management weaknesses, however, the draft plan is silent about how HHS plans to address these major operational issues. Including all major programs and activities in the draft strategic plan would help to identify their goals and hold managers accountable for achieving them.

Second, the plan does not always state the goals in a way that would allow future assessment of whether the goals have been met. Under the Results Act, goals are to be stated in a way that clarifies what results are expected from the agency's major functions and when results are expected. The draft plan is explicit, for example, in presenting an objective of reducing the number of uninsured children by half by the year 2002. More often, however, the discussions supporting the goals explain the processes and outputs of individual programs and activities without specifying their intended results. For example, one HHS goal is to promote self-sufficiency, but the draft plan only lists the programs and activities that support this goal. It is therefore unclear whether success will be measured by reducing

the number of people on federal assistance, improving the earning potential of families beyond certain levels, or some other means.

Third, some HHS goals relate closely to those of other agencies, yet the draft plan hardly discusses any coordination that may have taken place to ensure that these goals are complementary rather than duplicative or even contradictory. For example, the plan's discussion of HHS' responsibility for maternal and child health programs makes no reference to the Department of Agriculture's closely related Special Supplemental Food Program for Women, Infants, and Children. Similarly, the plan's section on health professions workforce programs does not discuss Department of Education programs for training health professionals. HHS' coordination of program goals with other agencies should help to conserve scarce funds, minimize confusion and frustration for program customers, and improve the overall effectiveness of the federal effort.

Approaches and Strategies Lacking in Draft Plan

HHS' strategic plan has not yet fully addressed the Results Act requirement to include the approaches and strategies for meeting goals and objectives. Under the Results Act, strategies are to describe the operational processes, staff skills, and technologies as well as the human, capital, information, and other resources needed to achieve agency goals. In addition, according to OMB Circular No. A-11, Part 2, these strategies should outline how the agency will communicate strategic goals organizationwide and hold managers and staff accountable for achieving the goals.

HHS's draft plan discusses its current programs and activities, but it does not discuss how these programs and activities will operate and meet the Department's goals. For example, the draft plan cites research supported by a number of HHS agencies on sexually transmitted diseases (STD). It does not, however, specify the types of research initiatives that are planned or under way or how they relate to a strategy for guiding clinical and public health practice in preventing and treating STDs.

Nor does the plan specify how HHS' various program strategies will work together to reach common goals. Many of HHS' programs developed over time as the federal government responded to new needs and problems, resulting in many cases in fragmented programs that may conflict with one another. Especially important, therefore, is HHS' need to identify and align individual program strategies to support achievement of its overall strategic goals and mission.

An example of the need to discuss strategies for linking program goals is the relationship between the child care and Head Start sections of the draft plan. The Temporary Assistance for Needy Families (TANF) program requires clients to increase their hours of work or work-related activity. The draft plan recognizes that as these parents increase their work hours, they will need additional child care services, and it mentions some HHS activities related to child care. The plan fails to note, however, that Head Start, which currently serves children of some TANF clients and therefore could meet child care needs to some extent, is limited by being generally a half-day, part-year program. Nor does the plan discuss strategies for coordinating these programs, such as increasing HHS' current efforts to encourage partnerships between Head Start grantees and child care providers, so that parents will have access to full-day child care services.[4]

In addition, HHS' draft plan fails to discuss additional resources the Department needs to reach its goals. For example, although the Health Insurance Portability and Accountability Act of 1996 adds new funds to fight fraud and abuse in the Medicare program, we have reported that this additional funding will still leave per claim safeguard funding in 2003 at about one-half the 1989 level after adjusting for inflation.

Similarly, the new welfare reform law gives HHS new administrative and oversight responsibilities, the performance of which will rely on data provided by the states. For example, using data provided by the states, HHS is to establish a national directory of newly hired employees and a registry of child support orders to strengthen child support enforcement. Yet the plan makes no mention of the financial and data resources HHS needs for this.

Moreover, HHS officials often cite changes needed in legislation or regulation to provide them with the flexibility they need to manage programs more effectively. For example, HHS has been working with the Congress to try to group large numbers of individual programs into consolidated program "clusters" to provide not only administrative savings but also greater flexibility to respond to changing national needs.[5] The draft plan does not discuss these and similar matters, however.

[4]Welfare Reform: Implications of Increased Work Participation for Child Care (GAO/HEHS-97-75, May 29, 1997).

[5]Health Professions Education: Clarifying the Role of Title VII and VIII Programs Could Improve Accountability (GAO/T-HEHS-97-117, Apr. 25, 1997).

Holding managers responsible for progress in meeting goals is a major focus of the Results Act as a whole. HHS' draft plan, however, does not discuss what means or incentives the Department will use to achieve this. By making managers responsible for the cost-effectiveness of programs and activities, the Results Act can help move managers from a traditional role as "caretaker" of federal programs to one of actively improving efficiency and reducing the costs of federal interventions.

Relationship Between Long-Term Goals and Annual Performance Goals Missing

HHS' draft plan does not define the relationship between the plan's goals and those it will include in its annual performance plans. The Results Act requires a description of these goals' relationship to help the Congress judge whether agencies are progressing toward meeting their long-term goals. Because HHS' draft plan has overlooked this discussion, it is difficult to know what many of the goals mean and how the Congress will evaluate whether they have been met.

HHS' draft strategic plan states that the Department's operating divisions and staff offices are developing the performance plans that will specify how resources will be used to meet goals and describe the objectives and targets relevant to specific programs. The Results Act, however, requires HHS' strategic plan to describe how the annual performance goals will relate to the strategic goals. One way to clarify the link is for the plan to define the performance measures that will be used. For example, HHS mentions using objectives in Healthy People 2000—which sets targets for national health promotion and disease prevention—for two of its strategic goals. The draft plan does not, however, clarify the relationship between these objectives and the programs and activities.

Little Mention of Key External Factors

HHS' draft plan pays only scant attention to some of the major external factors that could significantly affect the plan's goals. The Results Act requires HHS to discuss such factors and encourages the Department to identify actions that could reduce or ameliorate their potential impact. The act requires such a discussion to help HHS and the Congress assess the likelihood of HHS' meeting the strategic goals and determine the actions needed to meet those goals. A factor the draft plan does discuss is the impact of the growing size of the aged population on Medicare's solvency. The draft plan is silent, however, about other key factors. One major external factor missing from the draft plan's discussion is changes in the economy, which could significantly affect how and whether HHS meets its strategic goals. For example, although the nation is now in a period of

economic growth, diminished national or even regional growth could increase the demand on state health and income assistance programs when state revenues may be unable to meet the need. Implementation of welfare-to-work initiatives could also be compromised. As families' economic stress would grow, so too would the risks to their children, suggesting a need for increased attention to children's well-being.

Use of Program Evaluations to Establish or Revise Strategic Goals Not Discussed

HHS' draft strategic plan does not reflect the role program evaluation plays in structuring and refocusing Department goals and strategies. Such a discussion would help show the Congress that HHS has an evaluation system in place to ensure the reasonableness and validity of its goals and strategies as well as identify factors likely to affect performance.

Many evaluations of HHS programs by the Department, its OIG, and us have raised issues that will affect the Department's ability to implement the Results Act, yet the draft strategic plan does not address these issues. For example, many of these evaluations have pointed out that programs do not gather data necessary to evaluate their overall effectiveness. Other evaluations have pointed out the absence of systems to produce reliable performance and cost data needed to set goals, evaluate results, and improve performance. Several HHS and our own evaluations, for example, have pointed out the inability of the Department's health care shortage area systems to target over $1 billion spent by over 30 programs each year to alleviate medical underservice.[6] In addition, the midpoint evaluation of Healthy People 2000 reported that insufficient data existed to measure progress for over one-fourth of the initiative's 300 objectives.

Moreover, the draft plan does not reflect HHS' experience with its Results Act pilot programs, which could help the Department develop strategies for meeting its goals. For example, OCSE gained experience in developing strategic plans and working with diverse stakeholders. It also worked closely with state and local governments to develop national goals and performance measures.

The Results Act offers an opportunity for HHS to discuss in its plan the role of future program evaluations in improving performance and informing congressional decision-making. Many HHS programs established before

[6]Two of the most recent studies include Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995) and The Measurement of Underservice and Provider Shortage in the United States: A Policy Analysis, North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina (Chapel Hill, N.C.: 1994).

1990 have never been evaluated. HHS has authority to set aside up to 1 percent of PHS program funding for evaluations, which in 1992 amounted to $119 million. HHS has often used these funds for other purposes, however.[7] Refocusing these resources to evaluate program performance may provide HHS and the Congress with the information they need to explain reasons performance goals are not met and identify appropriate strategies to meet unmet goals.

HHS' Strategic Plan Reflects Key Statutory Authorities but Omits Others

A broad range of statutes governs HHS' activities.[8] Among these statutes, as reflected in the plan, are the Social Security Act (including, among others, programs pertaining to Medicare, Medicaid, child welfare services, child support, foster care, and adoption assistance); the Public Health Service Act; and the Federal Food, Drug, and Cosmetic Act. Major recent legislation includes the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (which, largely through amendments to the Social Security Act, authorizes TANF block grants, revises the child support enforcement program, and increases flexibility and funding available for child care programs) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Although HHS' draft plan generally reflects the key statutory authorities governing the agency's activities, it does not address all significant statutes and the programs for which HHS is responsible. For example, the plan says nothing about agency responsibilities such as regulation of the nation's blood supply, operation of a network for organ procurement and transplant, and certification of clinical laboratories and mammography facilities. The Results Act requires that the comprehensive mission statement and the general goals and objectives cover all major agency functions and operations. HHS specifically acknowledges, however, that its plan does not include all activities that contribute to the agency's overall mission—only those that HHS believes should have priority over the next 6 years.

[7]Public Health Service: Evaluation Set-Aside Has Not Realized Its Potential to Inform the Congress (GAO/PEMD-93-13, Apr. 8, 1993).

[8]When we performed our review, no comprehensive list of HHS' statutory responsibilities was available, and the draft plan did not provide any linkage between the mission, goals, and key statutory authorities. In view of the limited time available for our review, we could not comprehensively compare the plan with the statutory authorities governing HHS. We did not identify any major agency activity not grounded in explicit statutory authority.

Plan Pays Insufficient Attention to Crosscutting Programs

HHS' array of interrelated activities and responsibilities makes it especially important for HHS managers to work together to address the Department's overarching program goals. Moreover, many programs that are HHS' responsibility share goals with or relate closely to programs administered by other federal agencies. In addition to coordinating the activities of its own agencies, HHS must also coordinate its efforts with these other agencies. Although HHS' draft strategic plan recognizes that many different HHS agencies and programs are responsible for meeting each of the Department's goals, it does not discuss strategies for coordinating such efforts. Nor does the draft discuss HHS' need to coordinate its work with other federal agencies.

The following examples are a few of the many opportunities HHS has for its plan to discuss both intra- and interdepartmental crosscutting issues. One program area that requires HHS to focus on both internal and external coordination is alcohol and drug abuse treatment and prevention.[9] Programs addressing alcohol and drug abuse issues are located not only in several HHS agencies—including the Substance Abuse and Mental Health Services Administration (SAMHSA), NIH, ACF, and the Centers for Disease Control and Prevention—but also in 15 other federal agencies. These include the Departments of Veterans Affairs, Education, Housing and Urban Development, and Justice.

Substance abuse programs also have a bearing on other aspects of the Department's mission. HHS has previously reported that the number of child protective service (CPS) cases involving substance abuse can range from 20 to 90 percent, depending on the area of the country. Although the draft strategic plan mentions the use of illicit drugs as a major threat to the health of Americans and notes its impact on the complexity of family problems, it does not discuss how ACF and SAMHSA programs can work together to alleviate the problems that have produced a crisis for the CPS system.

Nor does the draft plan discuss HHS' work that overlaps with that of other agencies in addressing the dramatic increase in the number and severity of cases of child abuse and neglect over the last 20 years. HHS has recognized the need for interagency cooperation on child abuse issues and has participated in forums with the Department of Justice's National Institute of Justice, Office for Victims of Crime, and Office of Juvenile Justice and Delinquency Programs.

[9]Substance Abuse and Mental Health: Reauthorization Issues Facing the Substance Abuse and Mental Health Services Administration (GAO/T-HEHS-97-135, May 22, 1997).

Another example involves the new welfare reform law, which requires recipients to work after 2 years as a condition of receiving further benefits and requires states to achieve specified and increasing levels of recipient participation in work activities until the required rate reaches 50 percent in fiscal year 2002. State officials have expressed concern that as the most employable recipients find jobs, the remaining caseload will consist of individuals with substantial barriers to employment, making the higher target rates difficult to achieve. Although HHS' draft plan does not mention them, the employment, training, and education programs administered by the Departments of Labor and Education will probably be essential to TANF's success and to HHS' goal of promoting self-sufficiency and parental responsibility.

Finally, the draft plan does recognize the enormous impact the aging of the baby boomers will have on HHS programs. It does not, however, discuss the effects of this demographic change on related programs that affect economic well-being, such as Social Security and the Department of Labor's protections of private pensions, and the need for HHS to work closely with these other agencies to manage the consequences of such profound social change.

Strategic Plan Does Not Fully Address Major Management Challenges

HHS faces many major management challenges in carrying out both its program responsibilities and the type of strategic planning and performance measurement the Results Act requires.[10] Although HHS is aware of many of these challenges, its plan does not address them. By acknowledging these challenges in its plan, however, HHS could foster a more useful dialogue with the Congress about its goals and the strategies for achieving them. We would like to point out two areas in particular: HHS' reliance on state, local, and private agencies to carry out many programs for which it is responsible and the maintenance of financial management and program integrity.

Partnership With State and Local Agencies Makes Accountability for Results Difficult

Many HHS programs are operated by states, localities, or nongovernmental organizations, which requires HHS agencies to develop ways to make their many partners accountable for program results. In administering programs jointly with state governments or that involve many local grantees, HHS must continually balance program flexibility with oversight and maintaining program controls. To further complicate HHS' task, state data

[10]Department of Health and Human Services: Management Challenges and Opportunities (GAO/T-HEHS-97-98, Mar. 18, 1997).

necessary for meaningful performance measurement may not be currently available or may not be comparable from state to state.

The changes associated with recently enacted welfare reform exemplify many of these difficulties and will challenge HHS to assess the effects of reform on children and families. Under the TANF program, states have flexibility to design and implement their own assistance programs within federal guidelines, and HHS has a broad range of responsibilities for ensuring accountability from the states. The law also gives HHS authority to assess penalties if states fail to comply with certain requirements and provides for states to receive bonuses if they meet certain performance standards. HHS will need comparable and reliable state data to ensure that states are enforcing the federal 5-year lifetime limit on receiving welfare benefits, meeting minimum work participation rates, and maintaining a certain level of welfare spending, as well as to assess penalties and provide performance bonuses. Enforcing the time limit exemplifies the difficulty of HHS' task because information on the total amount of time a person has received welfare is often unavailable in an individual state, let alone across states.

Administering the Medicaid program presents the same difficulty in balancing flexibility and accountability. Federal statutes and regulations allow states substantial flexibility in designing and administering their Medicaid programs. Because HCFA is authorized to waive certain statutory requirements, such as those for managed care or home- and community-based service alternatives to long-term care, it may provide states with even greater latitude. Although HCFA performs structural reviews of waiver programs during the planning stage, problems have developed in some states as programs are implemented and continue to operate. Flexibility can be positive for beneficiaries as well as the states; however, HCFA's ongoing monitoring and oversight are important to ensure the appropriate use of federal funds. The need for accountability will be even more pronounced if the need for waivers to enroll beneficiaries in managed care is eliminated as the President and the Congress have proposed.[11]

Financial Management and Program Integrity Require Constant Vigilance

With HHS' broad range of programs, large number of grantees and contractors, huge volume of vendor payments, and millions of beneficiaries, the Department must constantly protect its programs from

[11]Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort (GAO/HEHS-97-86, May 16, 1997).

fraud, abuse, mismanagement, and waste. Safeguarding Medicare, the government's second largest social program, which in fiscal year 1996 had expenses of about $200 billion and processed 822 million claims, has been a long-standing management challenge for HHS.[12] The draft strategic plan recognizes the role of program integrity in meeting departmental goals in its discussion of Operation Restore Trust but does not discuss many important aspects of this issue.

The draft plan, for example, does not address HHS' problems in complying with GMRA. To provide decisionmakers with reliable, consistent financial data on the operations of federal agencies, GMRA requires each department and major independent agency to submit to OMB an audited agencywide financial statement beginning with fiscal year 1996. The magnitude of this task for HHS is extraordinary. HHS' expenses exceed $300 billion a year. Over 80 percent of this amount is spent by HCFA, primarily for the Medicare and Medicaid programs. Although the OIG tried to audit HCFA's financial statements in prior years, it could not express an opinion on the reliability of these statements mainly because of inadequate supporting documentation for some of the significant reported amounts. Financial management problems identified by the fiscal year 1996 financial statement audit effort include an estimated $23 billion in improper Medicare benefit payments made during that year.

Another critical challenge that HHS' plan does not address and that we have reported on is long-standing concerns about Medicare's claims processing systems. These systems do not allow for cross-checking of claims processed by carriers and intermediaries or for prepayment alerts of unusual increases in billing for particular items. HHS has been developing a single, integrated database system, the Medicare Transaction System (MTS), but ineffective planning and management of MTS modernization contributed to a substantial increase—from about $151 million to $1 billion—in the total costs estimated for developing and implementing this system. This occurred because HCFA did not carefully plan its MTS transition, effectively manage MTS as an investment, and fully follow commonly accepted system development practices. The MTS project is at risk of not meeting its revised schedule, which calls for completion of the design by October 1998. To address these issues, we made numerous

[12]Medicare: Inherent Program Risks and Management Challenges Require Continued Federal Attention (GAO/T-HEHS-97-89, Mar. 4, 1997).

recommendations to the Secretary of HHS that, if implemented effectively, would help ensure that a successful system will be delivered.[13]

HHS' draft strategic plan also fails to address the issue of information security that was identified during the fiscal year 1996 financial statement audit effort. HCFA's electronic data processing security program, which should provide a framework for managing risk, developing security policies, assigning responsibility, and monitoring the adequacy of computer-related controls, is ineffective. These weaknesses could allow unauthorized individuals to access sensitive medical history and personal beneficiary and claims data, and then inappropriately disclose or alter such data. HCFA's officials informed us that they plan to implement a plan to address this issue.

Agency Capacity to Provide Reliable Information on Meeting Strategic Goals Is Not Discussed

Nothing is more crucial to effectively managing an enterprise of HHS' size and scope than accurate information about programs and their effects. Yet HHS' draft strategic plan does not discuss either key aspect of the Department's capacity to provide needed information—the use of information technology and the availability of reliable data on program performance.

Recent information technology reform legislation, including the Paperwork Reduction Act of 1995 and the Clinger-Cohen Act of 1996, set forth requirements that promote more efficient and effective use of information technology to support agency missions and improve program performance. Under the information technology reform laws, agencies are to better relate their technology plans and information technology use to their programs' missions and goals. However, HHS' plan does not discuss how it plans to use information technology to achieve its missions, goals, and objectives, nor does the plan describe how HHS intends to use information technology to improve performance and reduce costs.

The plan is also silent on how HHS will meet the "year 2000" problem in connection with existing and planned automated systems. This problem stems from the common practice of abbreviating years by using their last two digits only. Thus, miscalculations in all kinds of activities—such as benefit payments—could occur because the computer system would interpret 00 as 1900 instead of the year 2000. HHS, along with other

[13]Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses (GAO/AIMD-97-78, May 16, 1997).

agencies that maintain time-based systems, must develop strategies to resolve this potential problem in the near future.

To implement its programs and meet its responsibilities successfully, HHS must have access to data that are both reliable and appropriate to the task.[14] Without such data, HHS cannot inform the Congress or the American people of its progress toward meeting its performance goals. For example, because several important HHS programs, including Medicaid and TANF, are joint federal-state efforts, the current lack of comparable data among states increases the difficulty of obtaining timely and reliable data.

The federal government has only limited data on the Medicaid program, some of which are of questionable accuracy. Some of these problems stem from collecting data from 50 states and the District of Columbia, which do not all use identical definitions for data categories. HHS' adoption of standardized data sets, as required by HIPAA, will provide a structure for reporting but will not solve other problems such as some duplicate reporting on the number of managed care enrollees.

Some of Medicaid's long-standing data problems could worsen because of the program's growing reliance on managed care to provide health services to beneficiaries. The proportion of Medicaid beneficiaries enrolled in managed care, as reported by HCFA, quadrupled from about 10 percent in 1991 to about 40 percent in 1996. Although HIPAA requires the adoption of a standardized encounter transaction format for managed care, unless proper and sufficient data are required for that format, HHS will still lack the detailed utilization data it needs to meaningfully compare the data available under fee-for-service billing. This, in turn, makes evaluating the program's success even more difficult.

Agency Comments

HHS officials agreed that the Department's draft plan omitted many of the elements required by the Results Act. They explained that the remaining elements of the plan are now being prepared and they expect that the plan will be complete by the time it is due in September. Even though they recognized in April when they released the draft that it did not contain all required elements, they believed that it was more important to allow enough time to consult with their many stakeholders, including state and local governments, than to devote the time to developing a more complete plan. They also believed that the plan as distributed in April provided a

[14]Department of Health and Human Services: Management Challenges and Opportunities (GAO/T-HEHS-97-98, Mar. 18, 1997).

sufficient framework for consultation. Furthermore, officials were concerned that providing a level of detail to the extent we have suggested would make the strategic plan a poor vehicle for communicating with the Department's stakeholders. Finally, they believed that it was important to recognize that the strategic plan was a work in progress and not a final product to be evaluated against the requirements of the Results Act. HHS' comments are included in enclosure II. HHS officials also provided technical comments, which we incorporated in the correspondence as appropriate.

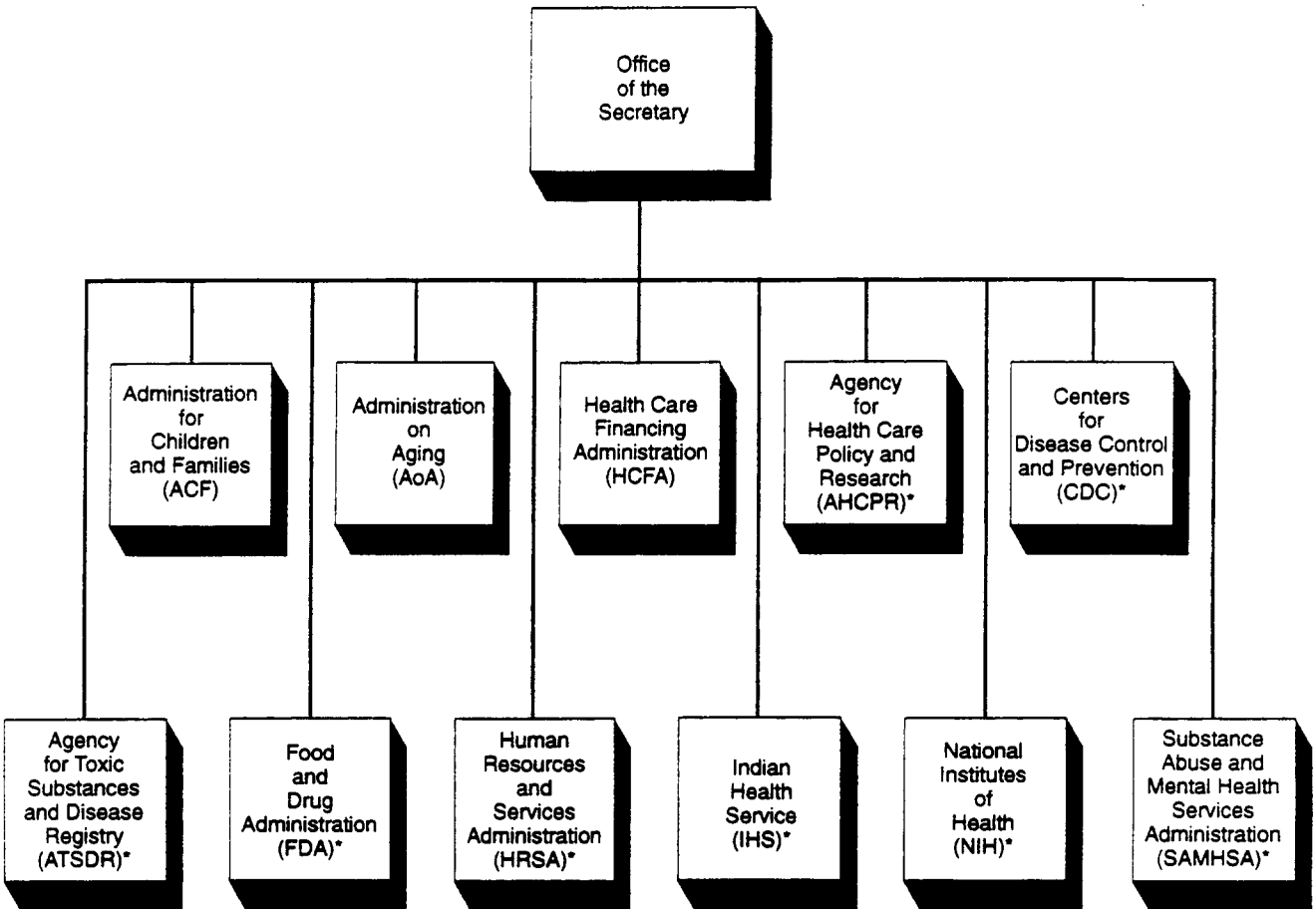
As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this correspondence until 30 days after its issue date. At that time, we will send copies to the Ranking Minority Members of your Committees; the Chairmen and Ranking Minority Members of the House Committees on Commerce and Ways and Means; the Secretary of HHS; the Director, Office of Management and Budget; and other interested parties. We will also send copies to others on request.

This work was done under the direction of Bernice Steinhardt, Director, Health Services Quality and Public Health Issues, who may be reached on (202) 512-7119 if you or your staffs have any questions. Other major contributors to this letter are in enclosure III.

Richard L. Hembra
Assistant Comptroller General

Enclosures - 3

HHS' Major Operating Divisions



Note: Operating divisions marked with an asterisk are part of PHS.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUL 9 1997

Bernice Steinhardt, Director
Health Services Quality and Public Health Issues
U.S. General Accounting Office
441 G Street, NW
Washington, DC 20001

Dear Ms. Steinhardt:

Enclosed is our formal response to the GAO report on the status of the HHS strategic plan. As I expressed in our meeting with you, we appreciate the opportunity to discuss our perspective and concerns regarding the observations made in the report.

Our response is in two parts. One part provides our reaction to the GAO findings in a form that can be included in the Agency response section of the report. The other part provides suggested edits to correct factual errors or make certain statements more accurate and balanced in tone.

The observations made in your report, as well as in our discussions, will be very helpful to us as we work to complete the HHS Strategic Plan by the September 30 deadline.

Thanks again for engaging us in the development of your final report and our final strategic plan.

Sincerely,

David F. Garrison
Principal Deputy Assistant Secretary
for Planning and Evaluation

Enclosures

JUL 9 1997

HHS COMMENTS ON GAO REVIEW OF HHS STRATEGIC PLAN

Overview

The Department notes that the strategic plan reviewed by GAO was produced in April for purposes of conducting stakeholder consultations required by the Results Act. Because of the number and complexity of its programs, HHS has an exceptionally large number of stakeholder groups--including State, local and tribal governments, universities, professional associations, and constituency groups that represent individuals served by the programs of the Department. We believed it important to give our stakeholders an opportunity to review and comment on the framework and strategic goals around which the Department's plan would be constructed. The plan was sent to more than 500 national organizations and to State and local governments. We have received a large number of comments on the plan, and they have consistently supported the framework and the strategic goals as providing an excellent roadmap for guiding our programs into the next decade. For example, one set of comments, reflecting the general response from State and local governments, stated: "by focussing on six overarching goals, HHS is signaling areas of policy priorities for the 21st Century that will serve as the baseline for State and local public health planning."

In selecting this strategy, we made a conscious decision to publicly distribute a plan that did not include an amount of detail beyond the basic framework of mission, vision and strategic goals. Most particularly, strategic objectives that provide the benchmarks for achieving the strategic goals were not included. This was done because our component agencies were still working on a parallel track with partners and stakeholders (including State governments) to develop performance plans, including performance objectives and measures, that are integrally linked to the strategic objectives that will be incorporated in the final plan. Therefore, rather than waiting to consult on a fully completed document, our process has involved work on additional parts of the plan (particularly the strategic objectives that will provide the benchmarks for measuring progress toward the strategic goals) in parallel with the public consultation process on the draft plan and our component's development and consultation on performance plan objectives and measures. This process has placed us on schedule to provide Congress with a completed plan in September that includes all of the required elements and incorporates the results of a very extensive and fruitful consultation with our stakeholder community, as well as assuring that the strategic plan and performance plans are substantially integrated. The premature GAO review of our plan thus fails to capture the full scope of the effort underway or to credit the importance of the consultation process and parallel efforts being made through our performance plan development process.

General Comments

Overall, the analysis is consistent with our own assessment of the changes necessary to provide a plan that meets all of the requirements of the Results Act by September 30, 1997. As stated, work is already underway to develop strategic objectives that will set measurable benchmarks toward achieving the strategic goals.

As you have noted, HHS is one of the largest federal departments, managing an exceptionally diverse and complex range of programs. In constructing our strategic plan, there has inevitably been a tension regarding the level of detail presented in the strategic plan. This is an important area in which we take exception to the findings you have presented. Providing the level of detail you suggest would produce a strategic plan document so lengthy and specific that it is no longer strategic or durable, and would be a poor vehicle for communicating with our partners, customers and the American people. Our preference is to develop a strategic plan, within which to integrate the broad range of programs across HHS agencies and with other departments. For example, although the final plan will anticipate any major new resource requirements needed to achieve the strategic objectives, we will use the Department's performance plan and related budget submissions to provide a detailed discussion of required resources.

More detailed comments on specific areas of criticism in the GAO report follow:

1. *HHS has not consistently identified strategies for achieving the goals or included measurable objectives.*

   The development of measurable objectives to support each goal has been underway in parallel with the public and Congressional consultation process on the plan. The plan that is submitted to the Congress in September of this year will contain strategic objectives and measures that will be used to assess progress toward achieving the objectives. The narrative also will include a more complete discussion of strategies that explain how the objectives will be achieved. It will also discuss how component agencies will coordinate their activities to achieve the Department-level goals.

2. *The plan does not sufficiently acknowledge that many other federal partners share responsibility for HHS program areas.*

   At the program level, there is significant planning coordination with other departments and agencies. For example, the strategic objectives that will underpin Goal 1 in the final plan have been developed in coordination with multiple other federal departments, States, tribal governments and private sector partners. Similarly the strategic objectives that will underpin Goal 2 have been coordinated with the Departments of Labor and Education and with our State and tribal government partners. In the area of drug abuse policy, the department has integrated its strategic planning efforts with the Office of National Drug Control Policy. Officials from HHS have chaired ONDCP working groups to develop the national drug policy goals, and objectives and have then integrated these back into the development of the HHS strategic objectives. This ongoing collaboration will be more clearly spelled out in the September 30th plan.

   Additionally, on May 14, 1997, HHS organized a government-wide conference (attended by representatives from more than 20 other departments and agencies) to explore some of the conceptual and practical issues involved with creating horizontal integration of objectives and measures across departments. This is an extremely difficult area where authorizing statutes, as well as the varying views of oversight committees and customer

groups, complicate the full integration of planning efforts. However, useful starts have been made and will be strengthened over the next year.

Also, we have circulated the Department plan to other departments (list can be provided) and asked them to review our plan, especially in areas of overlapping responsibility. We are reviewing other department plans as they are provided to us, and will initiate conversations about areas of collaboration and coordination, where appropriate.

As you noted in the report, HHS has been a leader in working on the difficult issue of defining performance measures for program activities where we share management with State and tribal governments. Over the past two years, we have worked with State governments with the help of a panel of data experts from the National Academy of Sciences to identify performance measures for a range of public health programs that are co-managed by the Department and State governments. The September 30th version of the Department's strategic plan will more fully discuss the complexity of this challenge -- including issues such as the data availability, approaches to defining shared expectations regarding performance, and how to most appropriately establish performance accountability for each level of government.

3. *Goals and Objectives Statements Are Incomplete.*

3a. *Comprehensiveness.*

We have tried to assure that the strategic goals and strategies in the plan cover the **major functions and operations** of the Department as required by the Results Act. For example, a major function of the Department is to promote the health of the American public. Several strategic goals address this function. Under those goals, we have provided examples of key program (statutory) activities that contribute to achieving the goals. We have not, however, tried to list all program activities that contribute since there are more than 300 programs in the Department. This would make the plan unwieldy. Rather, the contribution of all statutory programs and their relationship to each of the strategic goals will be more specifically delineated when the Department performance plan is complete. Each program and attendant performance objectives in the performance plan will indicate their relationship to the strategic goals and strategies.

In order to respond to the GAO concern, we are reviewing the plan to make sure all major functions and operations are covered. To do this, we have asked the HHS operating divisions again to review the plan to assure that we have not excluded any major functions or operations within their purview. We will take appropriate action based on that review.

3b. *Goals are not stated in a way that would allow future assessments of whether the goals have been met.*

The strategic objectives that will be added to the plan will provide the level of detail necessary to permit assessment of whether the strategic goals are being met. The prototype objective you noted with approval in the current draft (to reduce the number of uninsured children) is representative of the type of objective we expect to include in the revised plan.

3c. *Approaches and strategies lacking in draft plan.*

We are developing a more complete discussion of strategies that will be used to achieve the goals and objectives that will appear in the final strategic plan. This will also include a discussion of the various types of resources and other actions needed to carry out the goals and objectives.

3d. *Relationship Between Long-Term Goals and Annual Performance Goals Is Missing.*

The missing links between the long term goals and the annual performance goals are the strategic objectives. As previously noted, the Department has been working on the development of strategic objectives that will link the broad over-arching strategic goals with the annual performance plans for individual areas of program activity. The strategic objectives will permit measurement of progress toward accomplishing the strategic goals and will also create a direct link to the annual performance goals and targets in the annual performance plan. Taken together, the strategic plan and the annual performance plan will enable a reader to crosswalk between broad Department goals and individual programs that contribute to the accomplishment of that goal. A discussion of this relationship will be provided in the final strategic plan.

It would have been desirable for us to include the strategic objectives in the original strategic plan since that would have given both Congress and stakeholders a better opportunity to advise on those objectives. However, many of our program activities rely upon shared management with State and tribal governments. As you note in the report, we could not unilaterally recommend objectives without completing discussions and consultations with our partners. These discussions have been underway in parallel with our consultations on the entire strategic plan.

4. *Little mention of external factors.*

We agree that the discussion of external factors must be expanded. This analysis has been linked to our development of strategic objectives and will be included in the final plan.

5. *Uses of Program Evaluations to Establish or Revise Strategic Goals Not Discussed.*

(See item 10 response)

6. *Reflects Key Statutory Authorities But Omits Others.*

See comment 3a above.

7. *Insufficient attention to crosscutting programs.*

The Department has a number of major efforts underway to link together the programs that are necessary to achieve strategic goals and objectives across the Department and with other departments. These will be discussed in the September 30th plan. Examples, in addition to those noted in our earlier comment, include collaborative efforts with the Department of Justice in Operation Restore Trust and special focus areas relating to tobacco, adolescent drug use, quality and children's health. With respect to the demographic changes that are underway, the current draft of the strategic plan does state that HHS will provide leadership in fostering a national discussion of how to adapt public and private sector programs to the aging of the baby boomers. We naturally expect to collaborate in this effort with other departments and agencies.

8. *Strategic plan does not fully address major management challenges.*

We agree that the September 30th plan requires a fuller discussion of major management challenges. Management objectives will be integrated under the appropriate goals. A partial list of areas where management objectives might be appropriate includes:

- -- Information technology -- specific challenges such as MTS
- -- Fraud and abuse program activities
- -- Financial management -- particularly associated with "clean" financial statements and financial systems reliability
- -- Program data challenges -- for example those associated with State and local data availability

9. *Capacity to provide reliable information not discussed.*

We agree that the September 30th plan should include a discussion of critical data issues. As previously noted, we have invested significant efforts in the analysis of challenges we face in the areas of shared management responsibility with States and are working with state governments to identify approaches that can be used to capture timely, meaningful data. These issues will be more fully discussed in the final plan.

10. *Evaluation studies have not been adequately referenced.*

In the final strategic plan, the program evaluations and research that were used to develop the plan, and will be used in the future to measure the goals and strategic objectives, will be detailed. The purpose of this presentation is to provide Congress and other HHS stakeholders with information about the empirical knowledge base that supports the importance of the strategic goals and objectives. For example, formulation of the first HHS strategic goal—to promote health and reduce the major threats to healthy and productive lives for all Americans—was based on the same scientific research and evaluation underlying the Healthy People (HP) 2000 goals and objectives. The seminal research of Drs. McGinnis and Foege on the actual causes of death in the United States and the potential of this Nation to prevent premature death, improve the health of individuals, and reduce health disparities among special populations (Journal of American Medical Association, 1993) is only one illustration of the kinds of empirical data that have been brought into the planning process for both HP2000 and the HHS Strategic Plan.

We agree with GAO that it is crucial to have adequate data systems in place to measure progress under the strategic plan. It is equally important with respect to performance plan. In the data area we are making progress. The GAO review cites the HP2000 Midcourse Review as reporting the lack of adequate data on 29 percent of the 300 HP objectives; today the number of objectives with inadequate data has been reduced to only 18 per cent of the now 319 HP objectives.

Since the passage of the Results Act, HHS has been targeting more of its evaluation resources, such as those authorized under the PHS 1 percent set-aside authority, toward the development of performance measurement. For example, we have invested significant resources in developing performance measures for public health, substance abuse, and mental health programs in conjunction with our State and local partners. As another example, HRSA has invested more than $1.5 million over the last three years in developing and testing program measures or indicators for effective performance management. These efforts have been highlighted in the HHS annual report on evaluations titled, Performance Improvement 1996: Evaluation Activities of the U.S. Department of Health and Human Services.

Although significant efforts to address the targeting of evaluation resources to support the Results Act have been made, constraints remain as recognized by GAO. For example, we would point out that, although Page 17 of the GAO comments notes that HHS had $119 million in 1992 under the PHS 1% set aside for funding evaluations, in the intervening years Congress has increasingly earmarked 1% funds for other than evaluation purposes. In FY 1997, some $100 million of the total funds available (almost two thirds of the total) were earmarked by Congress for funding AHCPR and NCHS. This seriously compromises our ability to utilize fully the 1% authority to support evaluation activity including efforts related to the Results Act.)

Major Contributors to This Correspondence

Marsha Lillie-Blanton, Associate Director
Helene Toiv, Project Manager
Lacinda Baumgartner, Senior Evaluator
Lisanne Bradley, Senior Evaluator
Kay Brown, Assistant Director
Kay Daly, Senior Auditor
Mark E. Heatwole, Assistant Director
Christie M. Motley, Assistant Director
Dayna Shah, Assistant General Counsel
Stefanie Weldon, Senior Attorney

Related GAO Products

Medicare: Control Over Fraud and Abuse Remains Elusive (GAO/T-HEHS-97-165, June 26, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

Managing for Results: Analytic Challenges in Measuring Performance (GAO/HEHS/GGD-97-138, May 30, 1997).

Head Start: Research Provides Little Information on Impact of Current Program (GAO/HEHS-97-59, Apr. 15, 1997).

Child Welfare: States' Progress in Implementing Family Preservation and Support Services (GAO/HEHS-97-34, Feb. 18, 1997).

High-Risk Series: Medicare (GAO/HR-97-10, Feb. 1, 1997).

Medical Device Reporting: Improvements Needed in FDA's System for Monitoring Problems With Approved Devices (GAO/HEHS-97-21, Jan. 29, 1997).

Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas (GAO/HEHS-97-24, Nov. 22, 1996).

Child Support Enforcement: States' Experience With Private Agencies' Collection of Support Payments (GAO/HEHS-97-11, Oct. 23, 1996).

Drug and Alcohol Abuse: Billions Spent Annually for Treatment and Prevention Activities (GAO/HEHS-97-12, Oct. 8, 1996).

Information Management Review: Effective Implementation Is Essential for Improving Federal Performance (GAO/T-AIMD-96-132, July 17, 1996).

At-Risk and Delinquent Youth: Multiple Federal Programs Raise Efficiency Questions (GAO/HEHS-96-34, Mar. 6, 1996).

Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

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